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FIFTH ANNUAL REPORT ON MEDICARE FOR  
FISCAL YEAR 1971

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FROM

SECRETARY, HEALTH, EDUCATION AND WELFARE

TRANSMITTING

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THE FIFTH ANNUAL REPORT ON MEDICARE, COVERING THE  
PROGRAM'S OPERATION DURING FISCAL YEAR 1971, PUR-  
SUANT TO SECTION 1875(b) OF THE SOCIAL SECURITY ACT,  
AS AMENDED

SOCIAL SECURITY  
ADMINISTRATION



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THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE  
WASHINGTON, D. C. 20201

December 20, 1972

Honorable Carl Albert  
Speaker of the House of Representatives  
Washington, D.C. 20515

Dear Mr. Speaker:

Transmitted herewith is the fifth annual report on Medicare, covering the program's operation during fiscal year 1971. As you know, this report is required by section 1875(b) of the Social Security Act, as amended.

Sincerely,

A handwritten signature in black ink, appearing to read "Edward H. Richardson".

Secretary

Enclosure

93rd Congress / 1973-1974      5th report (1974)

REPORT ON MEDICARE

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FROM

THE SECRETARY OF HEALTH, EDUCATION,  
AND WELFARE

The Fifth Annual Report on the Operation of  
the Medicare Program, Pursuant to Section 1875(b)  
of the Social Security Act

## FOREWORD

As Medicare completed its fifth year its accomplishments could be measured in many ways. First and foremost, for the 21 million older citizens of this Nation and their families, Medicare has provided relief from the otherwise crushing cost of serious illness. In the past, a \$2,000 medical bill created severe financial strain for most of the aged, depleting their savings, requiring them to seek help from relatives or from a public agency. In one year, for example, one out of every 12 persons covered under Medicare was reimbursed \$2,000 or more for covered services. Of every \$5 in Medicare funds expended, \$2 went for this small, but most gravely ill, group.

Second, through Medicare needed hospital and medical care has been provided to many aged persons who might otherwise have postponed seeking care. About 6.3 million admissions involving 78 million patient days of hospital care were recorded in Medicare's fifth year. Added to this were 417,000 admissions to extended care facilities, 244,000 starts of care for home health services, and over 36 million claims resulting from care provided by the vast majority of the 255,000 non-Federal physicians involved in direct care of patients in the United States. About four-fifths of the persons enrolled for supplementary medical insurance used covered services under this part of the program, and more than 7 out of 10 persons in this group used sufficient services to be eligible for reimbursement. For many persons, early treatment of illness and disease may have meant postponement of disability and extended illness and a more useful and productive life.

A third major accomplishment has been the improvement in the quality of care in hospitals and related facilities through the certification process. As of July 1, 1971, participating providers included 6,745 hospitals with 1.2 million beds, 4,287 extended care facilities with almost 308,000 beds, 2,284 home health agencies and 2,751 independent laboratories. Since these providers also serve the general public, the impact of the Medicare program reaches well beyond its 21 million beneficiaries, reaching out to raise the standard of services offered to all persons by the health facilities in this Nation.

This fifth annual report on Medicare documents the program's operations from July 1, 1970 through June 30, 1971. It focuses on the administrative problems and the progress toward solution of these problems. In Medicare's fifth year, special emphasis was given to more effective and efficient operations, to improvement and enforcement of quality institutional standards, to the establishment of more effective controls on utilization of health care service, and to refining the policies and procedures governing reimbursement that will lead to incentives for provider efficiency and economy.

The first five years of Medicare have placed the program in the mainstream of health care financing for a significant segment of the population. The success of the program is due in large measure to the continued improved performance of the contracting intermediaries and carriers. As Medicare goes beyond its fifth year, we can look forward to continued administrative and procedural improvements to better meet the health care needs of this Nation's aged population.

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PART A. MEDICARE ADMINISTRATION

## I. CONTRACTOR ADMINISTRATION

### Claims Processing Performance

Since Medicare began, the Social Security Administration has been sensitive to the need for prompt and accurate payment of benefits, and it has continuously monitored the performance of its contractors,<sup>1/</sup> charged by law with claims payment responsibilities, to assure that claims are processed and paid as quickly and efficiently as possible. Medicare intermediaries and carriers were selected largely because of their demonstrated competence in claims processing in their own private business. Handling Medicare claims, however, taxed the resources and capabilities of many contractors, particularly carriers for the Part B program, and we frequently found it necessary to assist them in correcting deficiencies in their claims processing systems or establishing new systems altogether. The significant result of the combined efforts of SSA and the Medicare contractors has been a gradual but consistent improvement in claims processing operations.

Intermediary and carrier performance in carrying out their claims processing and payment function is assessed, in part, through certain selected quantitative factors. Those factors, while not completely measuring all the aspects of contractor performance, are being used as interim indicators of a contractor's ability to process its claims workload within reasonable time limits and at reasonable costs, pending the completion of a more integrated and comprehensive evaluative mechanism. A workgroup consisting of Social Security and carrier representatives has been involved in identifying and developing effective measures to reflect the cost, timeliness and quality of carrier claims processing operations.

Table I shows Part A intermediary bill processing time in mean days and the quarterly average percentage of bills pending over 30 days.<sup>2/</sup>

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<sup>1/</sup> See Appendix D, for discussion of the role of intermediaries and carriers in administering the Medicare program.

<sup>2/</sup> The reduction in intermediary processing time reflected after the second quarter of fiscal 1970 was partially due to changes in the method of computation. Processing time for bills received after December 1970 reflects the elapsed time from the date the bill is received by the intermediary until it is approved for payment. For bills received prior to January 1970, processing time reflects the elapsed time between the provider billing date and the date of approval for payment.

Part A intermediary mean processing time consistently showed substantial improvement. During the March quarter of fiscal 1971, for example, the average mean processing time decreased by almost 23 percent compared to the mean processing time during the same period in fiscal 1970. Mean processing time decreased by 37 percent compared to mean processing time for the March quarter of fiscal 1969.

The percentage of bills pending over 30 days increased slightly during the first quarter of fiscal 1971, compared to the same quarter in fiscal 1970. The percentage of aged bills during the other three quarters of fiscal 1971 compared with the same periods in fiscal 1970 decreased slightly. The overall intermediary performance on the aged bill percentages remained fairly constant during each quarter of both fiscal years 1970 and 1971, showing some small degree of fluctuation but resulting in gradual reduction in the annual percentages.

TABLE I--PART A BILLS

Qtr.	Contractor Processing Time (Mean Days)			% Bills Pending Over 30 Days		
	1969	1970	1971	1969	1970	1971
1	18.3	17.7	13.0	21.2	14.3	16.6
2	18.8	16.9	11.9	15.2	15.1	14.6
3	19.1	15.5	12.0	13.5	16.0	15.1
4	18.0	12.8	10.9	15.0	16.1	14.6
FY	18.6	15.7	11.9	16.2	15.4	15.2

Table II reflects Part B carrier processing time in mean days, the percentage of bills pending over 30 days, and the accuracy of accounting records submitted to SSA.

Part B carrier bill processing time improved during two of the three calendar quarters of fiscal 1971 compared with the same periods during fiscal 1970. Despite this improvement in bill processing time, however, the percentage of aged cases rose during all three quarters of fiscal 1971 compared with the same periods in 1970 and 1969. In part, increased receipts were responsible for the increase in aged caseloads reported by Part B carriers. The large number of carrier locations which were implementing new EDP systems during the year probably also contributed to the increase in aged claims. In fiscal 1971, three carriers implemented the EDS <sup>3/</sup> system, two converted to ASDC,<sup>4/</sup> and three locations implemented the Part B Model System.<sup>5/</sup> The short-term disruption in claims processing normally associated with systems changes, and the broad scope of those changes tended to increase the percent of claims pending over thirty days. In addition, it seems likely that increased emphasis by carriers on improving the quality of claims review tended to increase the percentage of aged cases. Carriers expended, for example, more money on such activities as utilization controls, quality controls and reconsideration and hearings. The accuracy of accounting records is quite good, and the error rate for 1000 records processed remained low throughout the fiscal year.

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- 3/ EDS (Electronic Data Systems) is a computer-oriented data processing system developed by a Texas-based firm. Discussion of it follows in this chapter.
  - 4/ ASDC (Applied Systems Data Corporation), a Rhode Island organization which has also developed a Part B claims processing system, discussed later in this chapter.
  - 5/ A Part B system developed by the Social Security Administration in collaboration with the Pilot Life Insurance Company, a former carrier, and the McDonnell-Douglas Automation Company.

TABLE II--PART B PROCESSING INFORMATION

	Contractor Processing Time (Mean-Days)			Percent of Claims Pending Over 30 Days <sup>6/</sup>			Accounting Errors Per 1,000 Records Processed <sup>7/</sup>		
Qtr.	1969	1970	1971	1969	1970	1971	1969	1970	1971
1	27.6	26.5	24.1	18.1	22.6	30.4	31	11	4
2	23.8	21.6	22.5	19.0	18.0	22.8	19	12	3
3	26.0	26.4	25.6	25.1	25.6	28.6	18	10	4
4	29.0	25.8	27.1	23.5	25.1	19.0	14	7	4
FY	26.6	25.1	24.9	21.4	22.7	26.2	20	10	4

Improvements in the quality of claims review have also resulted in more careful scrutiny of claims and more effective application of reasonable charge screens. This is reflected in the substantial increase (46.0 percent of approved bills reduced during fiscal 1971 compared with 30.7 percent in fiscal 1970) in the level of reasonable charge reductions which the carriers made.

#### REASONABLE CHARGE REDUCTIONS: FISCAL YEAR 1971

<u>Quarter</u>	<u>Percent of Allowed 1490's Reduced</u>	<u>Dollar Value of Reductions Per Allowed 1490</u>	<u>Total Value of Reductions Nationally</u>
July-September	39.1	\$6.03	\$ 57,069,760
October-December	43.9	6.96	69,142,627
January-March	49.1	7.41	82,698,891
April-June	50.5	8.26	82,622,530
Fiscal Year	46.0	7.16	\$ 291,533,808

6/ End-of-quarter pending for quarterly figures; average of monthly percent of aged claims for fiscal years.

7/ Errors affecting eligibility or payment information.

## Claims Processing Systems

### Model System for Part "A" Claims Processing

Two Model Systems were being developed during 1971 for processing Part A claims--one by the Blue Cross Association for use by its member plans, and the other by Aetna Life Insurance Society of America for use by commercial intermediaries. SSA monitored and guided their development to ensure that requirements of the law and regulations were incorporated and that the systems would perform at maximum efficiency.

Although both systems automate the claims process and perform essentially the same functions, they are designed to accommodate differing requirements of potential users. The BCA system consists of a number of small programs to accommodate users having small scale computer equipment. Plans having larger scale equipment would utilize the system in a multi-processing environment.<sup>8/</sup> Since most commercial users have large scale computer equipment, the Aetna system, in contrast, consists primarily of large integrated programs. In addition, the BCA system is designed to be operated at the user's location, while the Aetna system is designed to be operated either at the user's location or at regional locations utilizing central processing concepts. Both systems are flexible including a variety of options to allow for differing processing conditions. Both systems provide advantages in the control of claims from receipt to final disposition, speed of handling claims, savings in clerical time, and provision of information never before available. The two major advantages of the Model System development efforts which the Medicare program expects to realize are (1) the cost reductions which result from centralized systems maintenance and (2) control and elimination of duplicate systems development by individual intermediaries.

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<sup>8/</sup> BCA decided in 1972 to adopt a regional concept and added multi-plan processing capability to its system making it possible to tie together a number of Blue Cross plans into a single EDP processing operation. BCA plans in 1973 to redesign its system for large-scale computer hardware.

The BCA system was operating in three Plan locations by the end of fiscal 1971<sup>9/</sup> with 16 additional Plans scheduled to begin using it during fiscal 1972. The Aetna system was still being developed when 1971 ended.<sup>10/</sup>

#### The Part B Model System

During fiscal 1971, three additional carrier locations began using the Part B Model System, bringing to 11 the total number of carrier locations using the system.<sup>11/</sup>

The system was designed specifically to perform some of the more difficult processing functions. These include claims control, determination of reasonable charges, detection of duplicate billings and utilization controls. The system brings much needed uniformity to carrier claims processing functions, facilitates auditing and eliminates costly development of overlapping systems by individual carriers. How large any cost savings would be would depend upon the number of Model System users.

#### Other Part B Claims Processing Systems

Although the Social Security Administration evaluates available systems and is prepared to advise carriers on their relative advantages, the selection of appropriate claims processing systems is left to the individual carriers. Systems selected must fit within broad budgeting limitations, and any subcontracts for claims processing systems must receive Social Security's prior approval.

Under subcontract with Texas Blue Shield, Electronic Data Systems Corporation (EDS), a private Texas-based computer firm, developed a computer-oriented data processing system which, by July 1971, had been installed at nine carrier locations.<sup>12/</sup> The system

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- 9/ By mid-1972 the Blue Cross system was in use at eight Plan locations, with two plans operating on a multi-plan basis. Six other Plan locations were in some stage of implementing the system, and 23 other plan locations have been identified for implementation in calendar 1973.
  - 10/ The Aetna system became operational at Aetna's Hartford (Connecticut) field office on April 3, 1972 and is scheduled for implementation in 19 locations during calendar 1973.
  - 11/ Five additional carrier locations began using the system in fiscal 1972, bringing the total number of users to 16.
  - 12/ One more carrier began using the EDS system during fiscal 1972, increasing the total number of users to ten.

is administered by Electronic Data Systems Federal Corporation (EDSF), a wholly owned EDS subsidiary. Its capabilities have been expanded over time so that computer processes are now used throughout the claims processing system.

Carriers using the EDS system have been able to enhance the effectiveness and efficiency of their operations and have been relieved of the increasingly difficult tasks of maintaining extensive computer hardware and finding and retaining competent technical staff for EDP planning and programing. In addition EDS offers systems design and processing for all phases of a carrier's business, not just Medicare. The Blue Shield plans were more attracted by this aspect of EDS than the commercial insurance companies because they had not developed highly sophisticated EDP systems for their non-Medicare business as had the commercials.

Development of yet another Part B claims processing system was undertaken in March 1967 by the Applied Systems Data Corporation (ASDC) of Providence, Rhode Island. ASDC operated under a contract with Rhode Island Blue Shield calling for both development and installation of the system. By March 1968, the ASDC was completed and installed in Rhode Island, and by July 1971, it was being used by four carriers serving six states. Like EDS, ASDC can also supply systems which can be used in the carriers' regular business.<sup>13/</sup>

#### Other Claims Processing Developments

##### Use of Optical Character Recognition (OCR) Equipment

SSA's Bureau of Health Insurance worked with the Blue Cross Association and New York Blue Cross in developing a system for processing outpatient hospital claims using OCR equipment. A special form was designed which could be processed by a scanner or page reader. This machine "reads" data typed on a special typewriter and transfers it directly to magnetic tape without

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13/ The Intergovernmental Relations Subcommittee of the House Government Operations Committee began a series of hearings in September 1971 examining Medicare data processing arrangements and activities carried out through the use of subcontracts. The Subcommittee has been particularly interested in development costs and subcontracting arrangements. The transcript of those hearings, published under the title, "Administration of Federal Health Benefit Programs (Part 3 - Data Processing)" contains quite detailed data and other information about Medicare claims processing operations.

any keying of the data by the contractor. We estimate that this procedure will result in savings of \$5,000 a month at New York Blue Cross. We plan to extend this procedure to other intermediaries and to develop applications for other carriers and intermediaries.

#### Magnetic Tape Billing Procedures

By the end of fiscal 1971, 38 plans were submitting Part A bills on magnetic tape, an increase of five plans over 1970. The percentage of bills received on magnetic tape increased almost 10 percent, to a total of 50 percent, by the end of the year, representing savings of almost \$500,000 in key punching and handling costs.

#### Uniform Terminology for Part B Procedures

Development of a single, universally accepted system which doctors can use in describing and reporting what they do was the subject of greatly intensified study during fiscal 1971. The advantages of such a system are clear to physicians and third party payers alike. The major problem was reaching some agreement on a system acceptable to all interested parties. Medicare's concerns are that such a system (1) not escalate medical fees; (2) satisfy its program and statistical needs; and (3) be relatively permanent and not subject to revision every few years because of inadequate provision for expansion. We are concerned also that the system be flexible enough either to permit inclusion of services and items other than physician services or to be readily tied to a related system which does.

At the present time, three systems are under close scrutiny: (a) Current Procedural Terminology (CPT) by the AMA; (b) California Relative Value Scale (CRVS) by the California Medical Association; and (c) Manual of Statistical Requirements (MSR) by the National Association of Blue Shield Plans.

In March 1971, the Department sponsored a meeting attended by representatives of the medical community, the insurance industry and interested Federal agencies to discuss uniform terminology and development of a standardized system for recording and reporting health services. It was agreed at that meeting that Medicare and Medicaid would be the catalyst in promoting a uniform system which would meet the approval of major users. Because of its broad cost and quality of care implications for all the various health care related programs of the Department, the Health Services and Mental Health Administration has lead responsibility for this project. It anticipates that a new terminology system will have been developed and tested by five Medicare carriers early in 1973.

## II. EFFORTS TO ENFORCE MEDICARE QUALITY REQUIREMENTS

Anticipating that paying for large amounts of health care services through the Medicare program could affect the quality of those services, the Congress stipulated that adequate safeguards be established to assure that care provided Medicare beneficiaries not fall below a minimum acceptable quality. The law delineates certain specific requirements and authorizes the Secretary of HEW to promulgate health and safety requirements which participating providers must meet. In two situations, institutions which are accredited by independent facility accrediting organizations are deemed to meet Medicare's minimal requirements. The law provides that hospitals accredited by the Joint Commission on Accreditation of Hospitals "shall be deemed to meet the requirements."<sup>1/</sup> In addition, acting on authority granted by the law, the Secretary has ruled that hospitals accredited by the American Osteopathic Association are deemed to meet Medicare requirements. <sup>1/</sup>

With the exception of hospitals providing only emergency services and JCAH and AOA accredited hospitals, all providers of Medicare services and independent laboratories are periodically surveyed and certified as to whether they meet Medicare's requirements on quality of care.

Criticism of less than acceptable conditions in the nation's health care institutions, particularly nursing homes, continued to receive considerable publicity during fiscal 1971. The President's nursing home directives <sup>1a/</sup> established an eight-point action plan to improve long-term care and to coordinate and improve the activities of all Federal and State agencies responsible for the inspection and certification of facilities receiving Federal funds. They also provided for the expansion of the Federal nursing home standards enforcement capability and the designation of agencies within each State to deal directly with consumer complaints against nursing homes. In addition, substantial attention has been focused on the nursing home area by Congressional hearings and activities of consumer organizations. Public attention certainly should be drawn to these problems, which are really of long standing, but an underlying story, and one that is not generally known, is that during Medicare's first five years, a great deal of steady progress has been made in correcting deficiencies and in improving the quality of the services of health care institutions. The Medicare certification program, partly through its direct action, partly indirectly and through coordination with related programs, has had a large share of the responsibility for securing these improvements, which have included:

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<sup>1/</sup> Except for the utilization review requirements of the Medicare law and the non-discrimination requirements of title VI of the Civil Rights Act of 1964. As to these, specific findings of compliance must be made.

<sup>1a/</sup> Issued shortly after the close of fiscal 1971 (August 1971).

- Requiring that facilities are staffed on all shifts with enough qualified nurses to provide skilled care and are not relying upon aides who are untrained to recognize and handle patients' medical nursing needs.
- Requiring that qualified dietitians, pharmacists, pathologists, and other specialists responsibly oversee the operation of departments.
- Requiring the removal of fire hazards and the institution of fire protection procedures and equipment.
- Requiring that tissue committees, executive committees, etc., exercise effective policy control over all vital functions of hospital administration.
- Requiring utilization review committees in hospitals and extended care facilities to study the quality of care rendered and to review the medical necessity of care given in extended duration cases.
- Requiring good diet planning and adherence to nutritional standards.
- Requiring the assumption of proper physician responsibility for any therapies administered and for other personnel.
- Requiring control of dangerous drugs, which must be dispensed under direction of a pharmacist on proper physician's orders.
- Requiring remodelling for health and safety as, for example, the installation of nonelectrostatic floors in operating rooms or requiring separate rooms for the handling of germ-contaminated articles.
- Requiring hospitals to purchase modern lifesaving equipment such as cardiac monitors and defibrillators, and to train personnel to use this equipment.

Provider surveys are conducted to determine the compliance of participating health care facilities, agencies and independent laboratories with Medicare health and safety regulations. The requisite surveys are carried out by the State Health Departments under contract with us, although we have the

final say as to approval of the Medicare providers.<sup>2/</sup> When the surveyors find deficiencies, they, or other qualified consultants in nursing, pharmacy, dietetics, or other specialities, confer with the facility to work out a plan and timetable for correction and then continue to assist the facility until its problems are corrected.

During fiscal 1971, the 53 State agencies surveyed many of the 13,500 providers of services participating in Medicare and the 2760 approved independent laboratories and assisted those with deficiencies in making necessary improvements and corrections. While a considerable amount of this effort has related to staffing patterns and physical environment, about 3 years ago we instructed the States to begin placing greatly increased emphasis on assessing actual provider performance in the delivery of services. We asked the States to devote attention particularly to such things as: (1) determining whether the various provisions of the hospital's bylaws are being properly carried out; (2) reviewing clinical records and other key records; e.g., the operating room register, minutes of meetings of medical staff committees, minutes of meetings of the governing body, and reports of provider consultant personnel; (3) assessing the effectiveness of the tissue or medical audit committee and the policies and procedures related to tissue examination established by the medical staff; and (4) examining the records and proceedings of the utilization review committee, especially to find out whether that committee identified any evidence of unnecessary or inappropriate services being performed and whether appropriate corrective action was taken.

Medicare reimburses the State agencies for the cost of performing Medicare surveys and the related activities of assisting providers to upgrade. During fiscal 1971, we paid the States \$12,610,000 for these certification activities, a good investment in terms of the very significant quality improvements being obtained. There were more than 243 professional people employed by the states full-time on Medicare certification, and an additional 882 people shared with other programs who provide the manpower equivalent of 333 more full-time professional personnel. A study has shown that of all the different State health specialists involved in the surveys, half of them are experienced nurses. Others are certified sanitarians or engineers, hospital administrators, physicians, social workers, nutritionists, pharmacists, laboratory technologists, and medical record librarians. The success of the program in producing real improvement in the quality of care depends very heavily upon the work of these individuals. Therefore, we have exerted considerable effort to improve the

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<sup>2/</sup> Pursuant to section 1865 of the Social Security Act, however, hospitals accredited by the Joint Commission on Accreditation of Hospitals or American Osteopathic Association are deemed to meet all of the Medicare requirements except for utilization review. State certifying agencies, therefore, only survey and resurvey the operation of utilization review committees in accredited hospitals.

survey process itself.

1. A small staff of well-qualified survey specialists from the Social Security Administration worked with survey specialists in the Health Services and Mental Health Administration, PHS, in performing spot resurveys of facilities to validate the State surveyors' work. These teams conducted surveys in every State. Whenever they have discovered inadequate survey work, their findings have been made known to the administrator of the appropriate State agency, which is then required to reassess its certification of the institution we surveyed.
2. There have been a number of long-range training efforts designed to increase the capabilities and acuity of the State investigators. SSA assisted the Health Services and Mental Health Administration in developing university courses of study designed to cultivate an upgraded, evenly-trained cadre of State agency survey personnel. The Tulane University School of Public Health and Tropical Medicine has been giving a series of 4-week courses for surveyors, and comparable courses were offered by other educational centers during fiscal 1971.
3. We have experimented with various systems of "peer evaluation" to supplement the State survey process. As one example, we have utilized the capabilities of the California Medical Association, which for several years has carried on a voluntary hospital survey program designed to evaluate the effectiveness of medical staff activities and the quality of physician practice. CMA physicians survey the medical staff area of nonaccredited hospitals in California and make the results known to the California State Agency where they are incorporated in the survey report. The efforts of the CMA and California State Health Department are mutually reinforcing, and our policy is to encourage cooperation and the interchange of capabilities and information between them.

Since the conditions of participation represent standards of health and safety, and have a direct impact on patterns of institutional practice, we review the validity of the conditions of participation on a fairly continuous basis to assure that they continue to express the best currently accepted methods of health care administration. During fiscal 1971 we began revising the conditions of participation for all participating providers both to strengthen and upgrade them. Application of the revised standards, which will be more comprehensive in many areas than the present standards, should result in further improvement in the quality of care.

Independent of this comprehensive revision of the conditions of participation, we have identified specific aspects of the regulations which require improvement and made the necessary changes. Perhaps most significant among these was the revision of the hospital and ECF regulations to provide greater patient safety by requiring compliance with the Life Safety Code of the National Fire Protection Association. <sup>3/</sup> The Life Safety Code sets specifications for institutional construction and fire safety protection measures, and since it is also the standard established by law for nursing homes participating in the Medicaid program, this action sets a uniform standard for the Department.

Another important thrust is the effort to strengthen relationships among programs and organizations which have an interest in the quality of institutional care. Changes in Medicare regulations, for example, are being meshed with the new requirements of the Medicaid program. Medicare's adoption of the Life Safety Code is an example of this type of coordination. Every effort is being made to ensure consistent application of these requirements in individual situations. We have also tightened working relationships with JCAH and the American Osteopathic Association so that our positions will be compatible in establishing requirements that will have significant impact upon facility operation, e.g., installation of fire protection equipment. Similar relationships are maintained with the Association of State and Territorial Health Officers and a variety of organizations representing the health professions, national provider associations, health protection plans, and consumer groups.

When the conditions of participation were first promulgated, they were superimposed upon an assortment of State codes which were generally weaker and unevenly enforced. It was to be expected that after initial experience, ways would be seen to make the standards more effective, to improve provider understanding of them, and to improve their enforcement by the States. The pace of improvement has, in fact, picked up significantly.

Shortly after the close of fiscal 1971, we designated Social Security district offices as "listening posts" for public complaints about extended care facilities and nursing homes. Social Security field offices were instructed to ensure that these complaints were promptly acted upon. Those concerning providers certified under the title 18 program are sent to the Medicare State agency for investigation. Those involving title 19 (Medicaid) facilities are forwarded to the regional offices of the Social and Rehabilitation Service. Complaints against facilities not participating in either program are referred to the appropriate State agencies. Alleged title VI violations are forwarded to the regional offices of the Office of Civil Rights.<sup>4/</sup>

<sup>3/</sup> The regulations were issued October 28, 1971

<sup>4/</sup> As of March 1, 1972, 1983 complaints had been received under this program. All but 32 of them were referred to appropriate agencies for investigation; those not referred were judged not to require any action. Investigations of 380 complaints resulted in termination of one Medicaid facility and two facilities certified to participate in Medicare. State agencies have fully or partially substantiated 59 complaints and taken corrective action with the providers.

### III. FRAUD AND PROGRAM ABUSE

Fraud, abuse and other problems of program integrity continued to command considerable attention in 1971. News of ten fraud convictions broadcast in newspaper headlines across the country helped to increase the public interest and concern.

Forty Medicare cases of alleged fraud were referred to U.S. Attorneys for prosecution during 1971. <sup>2/</sup> The disposition of those cases is reflected in the following table:

<u>Action Taken</u>	<u>Number of Cases</u>
Conviction	10
Dismissal	--
Acquittal	--
"Nol Pros"	1
Declined to prosecute <sup>3/</sup>	10
Awaiting trial	9
Awaiting action by U.S. Attorney	10

Improvements in our detection efforts resulted in a 45 percent increase between fiscal years 1970 and 1971 in the number of cases of alleged fraud. Although there was a dramatic increase, 105 percent, from one year to the next in the number of cases cleared, our total pending workload nevertheless continued to increase. As of June 30, 1971, total pending workload had increased from 2,372 to 3,466.

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<sup>1/</sup> The term "program abuse" is used to describe incidents and practices which, although not fraudulent, may directly or indirectly cause financial losses to the Medicare program or its beneficiaries and their families. Where an abuse situation is identified, actions are taken to prevent recurrences and to recover any overpayments.

<sup>2/</sup> When potential fraud is discovered, SSA's Bureau of Health Insurance undertakes initial development. If its investigation reveals intent to defraud, the case is referred to the U.S. Attorney recommending prosecution.

<sup>3/</sup> A substantial number of these were recognized as cases containing factors making eventual prosecution unlikely. Under new procedures now in effect, a summary would be provided the Department of Justice but no submittal would be made with the expectation of obtaining prosecution.

MEDICARE FRAUD AND ABUSE WORKLOADS FOR FISCAL YEARS 1970 and 1971 4

	FY 1970	FY 1971	Increase	Percentage of Increase
Total Receipts . . . . .	3,916	5,672	1,756	45
Fraud . . . . .	1,853	2,326	473	26
Abuse . . . . .	2,063	3,346	1,283	62
Total Clearances . . . . .	2,253	4,615	2,362	105
Fraud . . . . .	970	1,898	928	96
Abuse . . . . .	1,283	2,717	1,434	112
Pending End of Year . . . . .	2,409	3,466	1,057	44
Fraud . . . . .	1,327	1,755	428	32
Abuse . . . . .	1,082	1,711	629	58

In an effort to reduce the pending backlog, we are concentrating more effort on continuing analysis of trends and problems in the national program integrity operation. From this, we expect to be able to identify areas in which procedural refinements can be introduced to streamline present methods of processing cases and to help us in determining priorities.

Prevalent Types of Violations

Analysis of all potential fraud cases received indicated that 47 percent involved allegations of physician billings for services not rendered. Sixteen percent were for hospital and other provider billings for services not rendered, and 17 percent involved double billings for a single service.

Assignment violations continued to dominate the abuse workload, constituting about the same proportion as last year, 57 percent. This kind of violation occurs when a physician who has accepted assignment from his patient nevertheless collects from the patient the difference between the amount which Medicare pays and the full charge he made for the service. Where contacts with the doctor prove ineffective to deal with the problems, suspension of the assignment privilege has been applied to control violations.

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4/ These figures represent cases in various stages of development ranging from initial allegations of fraud or abuse not yet investigated to completed cases containing evidence of intent to defraud the program now pending with U.S. Attorneys.

### Physicians with High-Volume Service

During the year, we continued the special project on which we reported in previous annual reports involving physicians who receive relatively large Medicare payments. The 1971 study involved physicians who received over \$25,000 in Medicare reimbursement during calendar year 1969 and whose patterns of practice seemed unusual in relation to other physicians in the area engaged in similar specialties. Approximately 1850 "solo" practicing physicians were involved in the study.

Payments were determined to have been proper in 1,346 of the cases reviewed. In 313 cases, current payments were suspended because of apparent overpayments, and 415 cases, including some suspended ones, were referred for peer review. We are still examining 91 cases. Through sampling techniques employed in this study, we have determined approximately \$4.8 million in gross overpayments of which about \$2.5 million has already been recovered by the carriers. The amount of overpayment will probably increase as more cases are returned from peer review and carriers complete their review of other cases still in process.

### Quarterly Program Savings Report

At the beginning of the fiscal year, we began preparation of a new Quarterly Program Savings Report designed to determine overpayments on a case-by-case basis and record the amount of money actually recovered, either through direct repayment or offset against subsequent valid claims, as the result of our fraud and abuse investigations. The report does not reflect direct savings to the beneficiary as a result of numerous investigations involving violations of billing procedures.

The following table reflects overpayments recovered during fiscal 1971.

<u>QUARTER</u>	<u>AMOUNT RECOVERED</u>
September 1970	\$1,011,037.12
December 1970	562,160.74
March 1971	542,141.85
June 1971	<u>1,886,616.49</u>
TOTAL	\$4,001,956.20

#### IV. UTILIZATION SAFEGUARDS

Since the Federal Government interacts with almost all health service providers and practitioners, the potential for its influencing change in the health care system is considerable. A potentially powerful vehicle for affecting such change is utilization review, a peer review mechanism 1/ through which professional judgments can constructively influence quality while helping to contain costs and assure that scarce and costly health services are appropriately used. The institutional health care community over years has given considerable attention to the utilization of inpatient hospital services, so that extensive data-gathering systems have been developed to identify variations in length of stay by particular diagnosis as well as related information on the composition of services provided.

There were a number of instances in which Blue Cross plans and other intermediaries began using statistical data to identify potentially inappropriate institutional utilization patterns and establish parameters to identify individual claims involving possibly unnecessary services. In Pittsburgh, for example, Blue Cross and other sponsors developed a hospital Utilization Program (HUP) which seeks to identify improper utilization in hospitals. The thrust of this program is educational and preventive, not the denial of claims. Other intermediaries are using statistical approaches to identify, by diagnosis, claims which involve possible overstays, or are using similar data in systems requiring preapproval of hospital stays exceeding specified numbers of days. Preapproval has been used by a number of States in connection with Medicaid and has been tried by some Blue Cross plans. For example, the New Jersey Plan has experimented with a requirement of advance approval for stays exceeding established norms for various diagnoses. The experiences, to date, with various forms of advance approval of services and prepayment review by diagnosis emphasize the difficulty of establishing uniform diagnostic guidelines which are effective in controlling overutilization and not overwhelming in terms of paperwork and professional review requirements.

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1/ Peer review was developed by the medical profession to provide to the individual physician the views and judgment of a group or organization of his professional colleagues regarding the quality and medical necessity of services he has provided. In the hospital insurance program, peer review is accomplished through utilization review committees which participating hospitals and extended care facilities are required to have. Their effectiveness has been spotty, however, and has varied with the kind and size of facility, the relative scarcity of beds, and the extent to which public programs and third-party insurers monitor their performance.

While the denial of individual claims helps to preclude improper expenditure of program funds and serves as a deterrent to overutilization, the emphasis on individual claims places a serious financial burden on the patient and tends to be costly and time consuming. We have sought to shift the emphasis to the identification of institutions with deficient utilization practices so that effort can be directed toward correcting the underlying problem.

From data compiled in administering the Medicare program, we have developed a system, Medicare Analysis of Days of Care (MADOC), which we expect to be useful in stimulating assessment and improvement of hospital utilization practices. MADOC uses summary statistical data to identify hospitals whose average length of stay differs significantly from the estimated length of stay for all hospitals in the area, taking into account differences in hospital characteristics, in the medical and demographic characteristics of each hospital's patients, in the treatment given patients and in specific geographic location. MADOC reports are issued semi-annually.<sup>2/</sup> They are based on length-of-stay data from short-stay hospitals for a 20 percent sample of Medicare beneficiaries. For some hospitals, this can mean that only a small number of cases may form the basis for the report's findings.

Where there are significant deviations in predicted utilization patterns, hospitals and intermediaries have been asked to undertake further intensive studies of various aspects of hospital practices by reviewing administrative and medical records to determine the reasons for apparently aberrant utilization patterns and the kinds of corrective action necessary. We have asked that particular attention be given to such areas as (1) the extent of elective weekend admissions, (2) scheduling of operating room use, and (3) delays in ordering and performing laboratory and x-ray tests, and (4) the extent of overstays due to lack of timely transfer of patients to ECF's.

Intermediaries have been instructed to take the initiative in contacting hospitals, where indicated by MADOC data, to assist them in identifying the nature and source of any potential problems which the data might suggest and to assure that any necessary corrective action is taken. How effectively MADOC data is used is being ascertained through quarterly intermediary reports and comparison of successive reports.

Use of MADOC by hospitals and intermediaries has varied considerably. Some intermediaries have reviewed small samples of medical records and patient charts and have reported such findings as patterns of admissions of questionable medical necessity and excessive post-operative care. A number of intermediaries and hospitals have resisted using the MADOC data. They allege unfamiliarity with the methodology used in deriving the data, that it is too complicated to use, that the sampling of cases is too small to reflect accurately the length of stay, or that the data is too old to be applicable to current utilization practices.

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<sup>2/</sup> The first MADOC report was issued in December 1970.

In an effort to gain greater understanding, acceptance and use of MADOC, we have met with providers, intermediaries, hospital associations, and others to explain the derivation of the data, their interpretation and application. We are summarizing and distributing information about the activities of intermediaries which have used MADOC successfully, and we also prepare detailed analyses for a few hospitals pinpointing specific factors which the MADOC reports indicate as requiring investigation.

Our belief that MADOC can be used to uncover hospital misutilization is supported by data from the Associated Hospital Service (AHS) which, at our request, identified eight hospitals from a recent MADOC report for further study. They selected a sample of about 50 cases from each of those hospitals and sent a physician-nurse team into each institution to review patients charts and related records. Of 46 cases reviewed at one institution, 15 (33 percent) revealed some misutilization. For the 15 cases, 138 out of 326 (42 percent) patient days involved inappropriate hospitalization due to admissions for diagnostic studies, prolonged post-operative stays, delays in obtaining laboratory tests, and convalescent or custodial care. Moreover, those results reflect the concurrence of the hospital's own utilization review committee after the fact. AHS informs us that the results at the other hospitals studied were quite similar.

Using MADOC and other data sources, including the claims review process, intermediaries are expected to be able to identify possibly aberrant utilization patterns and bring them to the attention of the providers involved. Since the key to effective utilization of hospital facilities must rest ultimately with an institution's medical staff, intermediaries are expected to work both with hospital administrators and the utilization review committees. Our continuing effort during fiscal 1971 was to persuade providers that effective, efficient and appropriate use of health care facilities is in the interest of both individual institutions and the Nation's entire system of health care. As more intermediaries and providers use MADOC reports as a mechanism for evaluating and realigning utilization practices, we expect the quality of both utilization review and claims review to improve.

Our efforts during fiscal 1971 were also concentrated upon the utilization requirement that has as its purpose the assurance of quality care by identifying and analyzing patterns of care. This aspect of utilization review has proved a difficult one for providers to grasp and implement. In addition, we continued our work with various medical societies in an attempt to develop better ways of accomplishing utilization review on an areawide basis. A number of areawide utilization review committees have been established under the sponsorship of county and local medical societies to perform utilization review for groups of extended care facilities. These have the advantage of providing greater flexibility in the availability of physicians for the review of cases and for performing medical care evaluations of services rendered by providers.

In Part B, the principal concern is with the effective utilization of physician services. Some questionable situations can be identified at the point of claims review before payment is made. These include such factors as the number of visits to or by the physician within a given time frame and the application of fixed tolerances on charges for particular services. Most carriers apply these screens in connection with the manual claims review process. Some computer prepayment screens have been introduced which have the advantage of relating the current claims data to that extracted from claims recently processed.

Postpayment screens use accumulated data on services provided by individual physicians, identifying aberrant patterns in the delivery of services. The carrier may then flag claims involving the particular physician for special review. The findings may be reviewed with the physician involved or referred for peer review and possible medical society action. Postpayment utilization screens take a number of forms but all use the basic principle of establishing a profile of services provided to identify aberrant situations.

We have supported an experiment developed between our carrier, California Blue Shield, and three California Medical Foundations, utilizing their expertise in utilization review as an integral part of the claims review process. The review employed by the Foundations is backed up with statistical data which they compile. In the full 12-month period of the study, reductions made by the Foundations amounted to \$569,000, or 3.3 percent of the claims volume processed.

During 1971, increasing attention was focused on the concept of establishing professional review organizations through which practicing physicians would assume the responsibility for reviewing utilization of services for which reimbursement is claimed under Medicare and other health insurance programs. We began, therefore, to undertake a program of demonstration projects designed to develop peer review prototypes and techniques and to assess the costs and feasibility of various peer review approaches and their effect on utilization of medical resources and quality of care. By the end of fiscal 1971, projects with the following organizations were in various stages of development: (1) The Sacramento Medical Care Foundation (to extend the foundation's certified hospital admission program (CHAP) to Medicare hospital and extended care facility admissions and home health starts of care);(2) the New York City Health Department (to develop prototype procedures for reviewing the utilization of institutional and professional services in hospitals); and (3) Blue Cross of Central Ohio and the Ohio Medical Advances Institute (to test a technique for identifying hospitals whose patterns of utilization are abnormal and remedying underlying problems).<sup>3y</sup>.

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<sup>3y</sup> Contracts were awarded to Blue Cross of Central Ohio in July 1971, to the New York City Health Department in January 1972, and to Sacramento Medical Care Foundation in July 1972.

## V. MEDICAL INSURANCE ENROLLMENT AND PREMIUM PAYMENT

Anyone attaining age 65 who is a citizen, or an alien admitted for permanent residence (who has resided in the United States continuously during the five years immediately preceding the month in which he applies) or who is entitled to hospital insurance benefits under Part A, is eligible to enroll in the supplementary medical insurance program. An individual may enroll during a 7-month initial enrollment period which begins with the third month before the month he attains 65. During each month of fiscal 1971, approximately 120,000 enrolled in the program during their initial enrollment period. As of July 1971, 19,800,000 people, representing 96 percent of those entitled to hospital insurance were also enrolled in the medical insurance program.

A person who misses the initial opportunity to enroll, who is terminated for failure to pay premiums, or who voluntarily withdraws from the program may enroll or reenroll during a general enrollment period (the first three months of each year) which begins within 3 years after the end of his initial enrollment period. An individual may reenroll only once. Experience in the 1971 general enrollment period closely paralleled that in 1970. During the last week in January 1971, SSA canvassed 268,400 individuals living in the United States who did not have medical insurance coverage because they had never enrolled, had coverage terminated, had voluntarily withdrawn from the program, or had never responded to prior solicitations. Of about 170,000 individuals who responded, 115,600 elected medical insurance coverage and 54,500 refused coverage. The results in 1971, 43 percent enrollment of those canvassed, were similar to the results in 1970 when 46 percent of those canvassed enrolled.

Unless there is a change in the law removing the 3-year limitation or the two time limitation on enrollments, we expect the GEP activity to stabilize at 250,000 potential enrollments in a year. If this time limit were removed approximately half a million individuals currently excluded would be eligible to enroll. 1/

### State Buy-In of Part "B" Coverage

Under the Medicare law, States were permitted to enter into agreements with the Secretary, based on a request made before January 1, 1970, to buy-in-- that is, to enroll and pay the medical insurance premiums for public assistance recipients age 65 or over who were receiving money payments under an approved public assistance plan and for people eligible to receive medical assistance under an approved Medicaid plan. A State could limit the agreement to cover only individuals (other than monthly social and railroad retirement beneficiaries) who receive money payments under an approved public assistance plan, or it could cover individuals, including monthly social security and railroad retirement beneficiaries,

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1/ Under a provision of H.R. 1, 92nd Congress, the 3-year enrollment limitation would be eliminated. The President signed H.R. 1 into law on October 30, 1972.

who receive money payments under an approved public assistance plan, or it could cover all aged persons determined eligible to receive medical assistance under Medicaid, whether or not they receive monthly social security or railroad retirement benefits or whether or not they receive money payments.

As of January 1, 1971, 46 States, the District of Columbia, Guam, and the Virgin Islands had active buy-in agreements enrolling approximately 2.0 million public assistance and medical assistance recipients in the medical insurance program. Of these, 24 States and three jurisdictions have agreements which cover all aged persons determined eligible to receive medical assistance under Title XIX (Medicaid), 20 States have agreements which cover only individuals receiving money payments under their approved public assistance plans, and the two remaining States have limited their agreements to cover only non-monthly social security and railroad retirement beneficiaries who are receiving money payments under an approved public assistance plan. In addition, prior to January 1, 1970, two States and Puerto Rico submitted requests to enter into agreements in the future and six other States submitted requests to expand their coverage groups to include the "medical assistance only" eligible under Title XIX.

#### Premium Collection

Unlike the hospital insurance program which is financed through contributions made during working years, the medical insurance program is financed through monthly premiums paid by those who enroll in the program and by equivalent payments made from the general revenues of the Federal Government. The premium rate during fiscal 1971 was \$5.30 per month. It was increased to \$5.60 per month beginning July 1971, and effective July 1972 was again increased to \$5.80 per month. 2/

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2/ The Administration has recommended that the premium payment be eliminated and that the medical insurance program be financed under the contributory social security system. H.R. 1, as passed by the 92nd Congress, provides that the premium would increase in any given year only if monthly cash social security benefits had been increased in the interval since the premium was last increased and would rise by no more than the percentage by which cash benefits had been increased. Funds could be authorized to be appropriated from general revenues sufficient to meet the cost of the medical insurance program beyond those met by the premiums. H.R. 1 became law on October 30, 1972.

For individuals receiving social security cash benefits, railroad retirement benefits, or Federal civil service annuities, premiums are deducted from monthly benefit checks. Approximately 15 million people have their premiums paid in this manner. In addition, about 1.2 million people are billed directly at the beginning of each calendar quarter, and an additional 130,000 are billed in each of the other 8 months of the year. Approximately 2 million people have their premiums paid under State buy-in agreements and 102 organizations pay premiums on behalf of their membership totalling about 42,000. 3/

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3/ In January 1971, the new SOBER(Separate Operation for Billing, Entitlement and Remittance) system was implemented. This system has permitted us to exercise increased control over the entire billing, and collection operation. In addition, it has facilitated the processing of post-entitlement actions through the payment centers, thereby improving service for many of our beneficiaries.

## VI. THE DIRECT-DEALING CLAIMS OPERATION

Providers of health services participating in the Medicare program are paid either through private and public contractors which serve as fiscal intermediaries, or, if they choose, directly by the Government. Although the vast majority of providers chose to deal with the Government through intermediaries, about 650, representing about 3 percent of all participating providers, elected to deal directly with the Government. They include hospitals, extended care facilities, home health agencies, and rehabilitation centers. They are dispersed among 34 States, the District of Columbia, and Puerto Rico, and provide multiple levels of care. About 80 percent of them are State or municipally-controlled providers, including nine State hospital systems, St. Elizabeth's Hospital in the District of Columbia, Puerto Rico's hospital system, New York City's hospital system and four State home health systems. In addition, approximately 418 Defense Department, Public Health Service and Veterans Administration hospitals, located in all 50 States, deal directly as Federal emergency hospitals. Approximately 1.5 percent of the national Part A claims processing workload is generated by direct-dealing providers, ranking SSA's direct-dealing operation fourteenth among some 160 intermediary processing centers.

Direct-Dealing Provider Classification as of June 30, 1972

Type of Provider	State/Municipal	Other	Total
Hospital	173	33	206
ECF	13	65	78
HHA	349	12	361
PT	0	4	4
<b>Total</b>	<b>535</b>	<b>114</b>	<b>649</b>
Federal Emergency Hospital	418	0	418
<b>Grand Total</b>	<b>953</b>	<b>114</b>	<b>1,067</b>

The claims process for direct-dealing providers essentially parallels that followed by intermediaries. Direct-dealing providers have certain unique characteristics, however, which affect the entire claims processing operation and introduce complexities and problems not experienced by any intermediary. They are, for example, widely dispersed geographically, and their dispersion poses communications problems for the Government's direct-dealing operation unexperienced by intermediaries, which serve providers in relatively compact geographic areas. The largeness and diversity of State and municipal hospital systems also cause complications for the direct reimbursement operation. In addition, a much larger percentage of problem providers deal directly with the Government than with any single intermediary. Unlike intermediaries, the Government cannot refuse to accept a participating provider which wants to deal directly. The result is that direct-dealing involves a large number of providers whose administrative capability is low, whose records are poor, and whose claims tend to contain more errors and require more extensive development. Problem providers consume time far out of proportion to other providers of like size.

During fiscal 1971, there was a slight increase both in the number of direct-dealing providers and in the claims workload:

FY	Hosp.	ECF	HHA	PT	Total <sup>1/</sup>	Bills	Money
67	202	37	30 <sup>2/</sup>	--	269	116,237	\$ 39.5
68	237	29	27 <sup>2/</sup>	--	293	297,607	69.1
69	239	44	26 <sup>2/</sup>	1	310	492,595	110.3
70	228	50	392	4	674	382,640 <sup>3/</sup>	94.6
71	213	86	391	6	696 <sup>4/</sup>	696,137 <sup>4/</sup>	104.8

All money amounts shown in millions

1/ As of June 30 each fiscal year.

2/ There were about 334 HHA units reporting to a central office which were not included in these FY statistics.

3/ The decrease in number of provider billings from FY 1969 to FY 1970 can be accounted for by a delay in providers' submission of Part R tape billings, i.e., 102 received during FY 1970 as compared to 120,000 received during FY 1969. Such billings are now being received and processed on a regular basis.

4/ During fiscal 1972, there was a slight decrease in the number of direct-dealing providers (649) but a large increase in the claims workload (1,293,587).

Despite the problems inherent in the operation, a study of SSA's processing of its direct-dealing workload indicated that 1.62 claims from direct-dealing providers were processed per man-hour at an average cost of \$3.68 per claim. In making this computation, the study used the average expenses of the direct-dealing operation during the last half of calendar 1971 (\$12,093, including travel and equipment) and applied it to the 328,424 bills processed using 200 man-years during the six-month period.

In addition to serving the Part A intermediaries which deal directly with the Government, our direct-dealing operation also performs the functions of a Part B carrier for eight of the direct-dealing State hospital systems, the New York City hospital system, two Pennsylvania tuberculosis hospitals, the Federal emergency hospitals and St. Elizabeth's Hospital. It also serves 29 direct-dealing group practice prepayment plans.

## VII. MEDICARE ADMINISTRATIVE COSTS

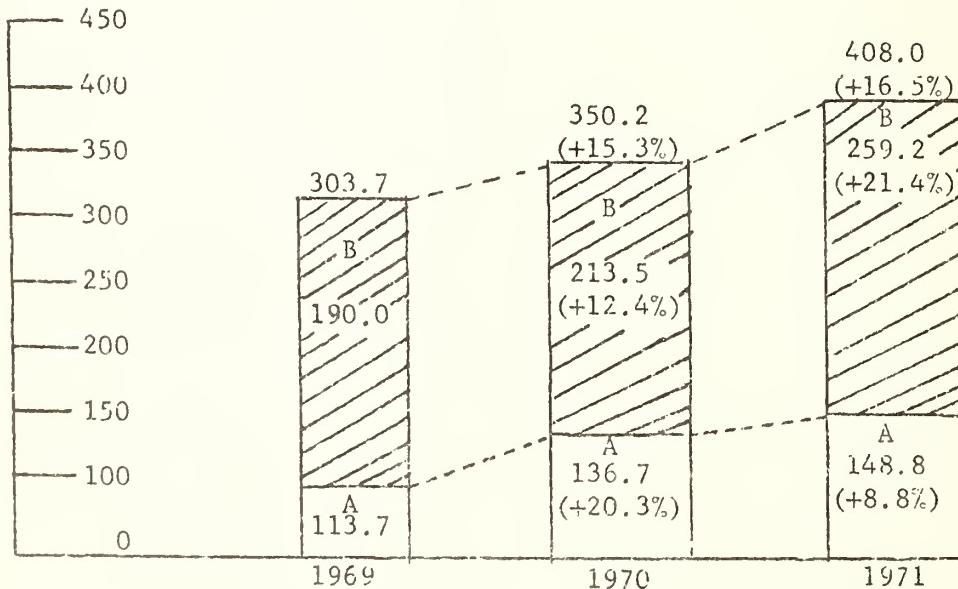
In fiscal 1971, Part A administrative costs rose 8.8 percent, a considerably smaller increase than in 1970, when administrative costs rose 20.3 percent.

Two important factors in this growth of administrative costs were (1) workload increase of 4.4 percent, and (2) the continuing inflationary pressures that have increased average salaries and raised most price levels.

The slower rate of increase in 1971 as compared to 1970 was due primarily to a policy change authorizing final settlement of provider costs without audit in certain cases, and encouraging extensive use of limited scope audits in other situations. Auditing costs, one of the largest administrative costs, have been significantly reduced as a direct result.

Part B administrative costs rose 21.4 percent reflecting (1) workload increase of 11.8 percent, (2) continuing average salary and price level increases similar to those mentioned above, and (3) the costs of our efforts to improve the quality of claims processing and considerably intensified efforts in developing and implementing EDP systems improvements.

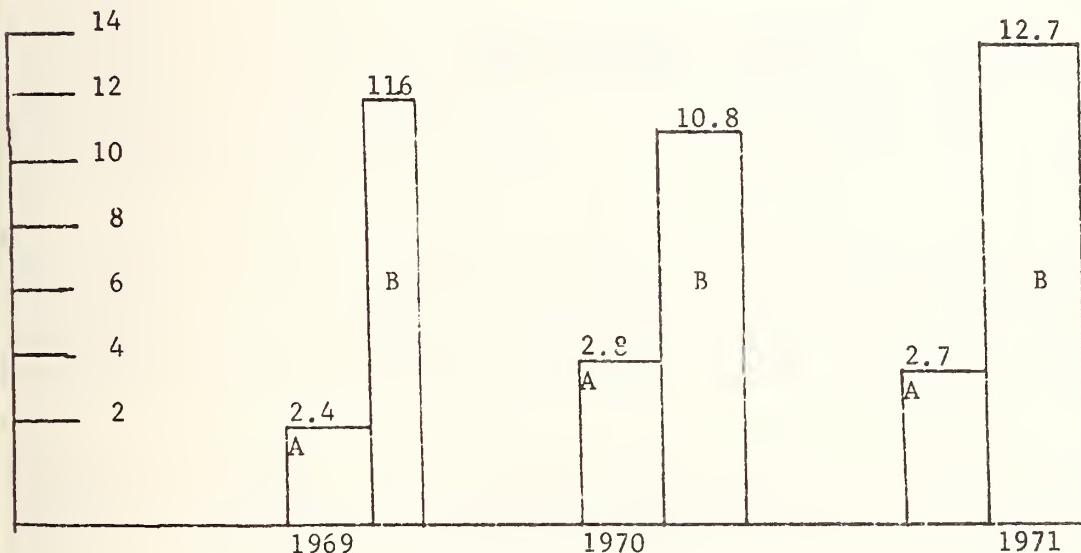
Part A and Part B  
Administrative Costs  
(million \$)



Viewed as a percentage of benefit payments, Part A administrative costs fell from 2.8 percent in 1970 to 2.7 percent in 1971. In Part B, however, administrative costs rose from 10.8 percent of benefit payments to 12.7 percent of benefit payments.

The difference in the cost of administering the two programs is due primarily to the essential differences in the nature of the programs and in their reimbursement mechanisms. Unlike Part A, Part B of Medicare involves the processing of a large volume of small claims. The average benefit payment in Part A is about seven times greater than in Part B. Also, Part B carriers must maintain extensive records used in determining reasonable charges for physicians' services. These records have no Part A counterpart.

Part A and Part B  
Total Administrative Costs as a  
Percentage of Benefit Payments



PART B. REIMBURSEMENT

## VIII. PROVIDER REIMBURSEMENT

Participating providers of health care services are reimbursed the reasonable cost of covered services furnished Medicare beneficiaries. Because the actual costs of delivering patient care vary widely from one provider to another due to differences in provider size, level of care, scope and utilization of services, geographic location, and other factors, the reasonable cost basis of reimbursement is intended generally to meet the actual costs incurred by a provider in rendering patient care.

As health care costs continued their rapid increase during Medicare's fifth year of operation, so too did the concern that Medicare reimbursement on the basis of the cost actually incurred by providers in furnishing covered services to beneficiaries may not offer adequate incentive for provider efficiency and economy.<sup>1/</sup>

While recognition of incurred costs for Medicare reimbursement purposes is subject to the limitation that such costs be reasonable and not substantially out of line with the costs of comparable providers in the same area, this limitation has been difficult to apply effectively. Moreover, the disallowance of costs as unreasonable after they have been incurred creates financial uncertainty for providers, with resulting problems in administrative planning, and can cause them serious financial difficulties.

While the solutions to the basic problems of traditional cost reimbursement which is geared to providers' actual costs and determined retrospectively are of a kind that require specific legislative authority, the program has continued to move forward in refining the policies and procedures governing Medicare reimbursement under present law.

Because of its potential for increasing the cost control effectiveness of Medicare reimbursement, increasingly greater emphasis was placed on the "prudent buyer" concept during fiscal 1971 in identifying and disallowing

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<sup>1/</sup> Instructions were issued in May 1972 to implement the President's economic stabilization program with regard to Medicare reasonable cost reimbursement to providers. The instructions provide that Medicare reimbursement on a per unit-of-service basis for services rendered on or after January 1, 1972, may not exceed the reimbursement payable for the preceding reporting period by more than 6 percent for institutional providers (hospitals, ECF's, hospital-based HHA's) or 2.5 percent for noninstitutional providers (free-standing HHA's and outpatient physical therapy providers) after making adjustments for changes in the intensity of services provided.

unreasonable costs incurred by providers in purchasing supplies and services. Implicit in the statutory provision that a provider's costs be paid to the extent that they are reasonable is the expectation that the provider will not only refuse to pay more than the going price for the supplies and services it purchases but will seek to minimize its costs, e.g., by attempting to secure quantity discounts on bulk purchasing of supplies. Under the prudent buyer policy, a provider is considered to have incurred unreasonable costs if it paid excessive prices for purchased supplies or services or obtained services under arrangements with an outside supplier which it could have secured more economically by employing personnel to perform them. In general, application of the policy places on the provider the burden of showing that the costs it incurred were reasonable, i.e., it was not feasible to obtain the supplies or services in a more economic manner. While the prudent buyer concept is applicable to all supplies and services used by providers, the initial emphasis in implementing the policy has been on those ancillary services and supplies purchased by providers from outside suppliers for which Medicare reimbursement is large. Costs determined to be excess of what prudent and cost-conscious buyers pay for a given item or service are not reimbursable.

Another administrative improvement in fiscal 1971 was the publication of regulation changes on August 1, 1970, which reduced the possibility of excessive reimbursement through the use of accelerated methods of depreciation and narrowed the possibility of inflated valuations of provider assets in determining the bases for depreciation, return on equity capital, and allowable interest. The regulations provide for recovery of excess depreciation if a provider terminates or substantially reduces participation in the program after the years of highest accelerated depreciation allowances, restrict the use of accelerated depreciation for assets acquired on or after August 1, 1970, expand the conditions under which gains or losses on sales of depreciable assets are considered in determining provider costs, and generally eliminate the recognition of "goodwill" in determining the base on which reimbursable interest and the return on equity capital are computed.

With the discontinuance, as of July 1, 1969, of the allowance in the Medicare reimbursement formula for providers' costs not otherwise specifically recognized by the formula, the program sought to identify changes that would insure that the reimbursement formula specifically recognizes all appropriate elements of provider costs. After consultation with leaders of various health care organizations, including the American Hospital Association, final regulations were published on July 2, 1971, establishing an inpatient routine nursing salary cost differential of 8½ percent (until the rate is redetermined), retroactive to July 1, 1969, to take account of the above average use of inpatient routine nursing services by the aged.

Since interim payments on billings are made on the basis of estimated costs and, in the aggregate, may result in an overpayment or an underpayment to the provider, a retroactive adjustment is necessary after the provider's actual reimbursable costs are determined. In order to reimburse the provider as quickly as possible, a tentative retroactive adjustment (to be followed by a final retroactive adjustment) may be made as soon as the cost report is received, after taking account of obvious errors and inconsistencies. In order to reduce the possibility of unrecoverable overpayments as a result of tentative retroactive adjustments, however, instructions were issued in April 1971 to clarify that such adjustments should not be made (1) on a cost report filed by a terminated provider or the former owner of a provider that has changed ownership, (2) where the provider is bankrupt or insolvent, or (3) where a change of ownership has occurred and the intermediary has not been satisfied of the acceptability under program regulations of any increase in the basis for depreciation of the facility as claimed by the new owner. It was further specified that both tentative and final retroactive adjustment payments should be reduced by any monies the provider owes the program.

To assure that all situations involving substantial overpayments are handled fairly and uniformly in a manner that safeguards the government's interests, detailed procedures were also published in April 1971 for computation and expeditious recovery of any overpayments arising as a result of excessive interim rates of payment, failure to file cost reports, or a pattern of furnishing and billing for excessive services which are neither reasonable nor medically necessary or noncovered services.

Shortly after the year closed, final regulations were published<sup>2/</sup> establishing the basis for making accelerated payments and recovering them. The regulations provide that an accelerated payment may be made upon request by a provider which is experiencing financial difficulties due to intermediary delay in making payments or, in exceptional situations, by a provider which has experienced a temporary delay in preparing and submitting bills beyond its usual billing cycle. As a safeguard, provision was made for prior approval of accelerated payments by both the intermediary and the Social Security Administration.

We undertook in fiscal 1971 to develop simplified cost finding and reporting requirements for smaller providers and improve apportionment requirements under which actual costs of provider services are determined and Medicare's share of those costs is related to the actual costs of services received by beneficiaries. As a result, revised regulations

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2/ Federal Register, September 18, 1971.

have been published<sup>3/</sup> which (1) require use of the Combination Method of apportionment for all extended care facilities and for hospitals having fewer than 100 beds, (2) require use of the Departmental method of apportionment by all other hospitals, (3) revise the Departmental Method to require apportionment of routine service costs on an average cost per diem basis, (4) provide for separate average cost per diem apportionment of intensive care units, coronary care units, and other special inpatient hospital units; (5) provide specifically for non-recognition of the cost of luxury items or services, (6) exclude delivery room costs under both the Combination and Departmental Methods, and (7) provide for simplified cost-finding procedures for providers required to use the Combination Method.

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<sup>3/</sup> Proposed regulations were published in the Federal Register on December 2, 1971, under a notice of proposed rule making, and final regulations were published on May 20, 1972.

## IX. PROGRAM EXPERIMENTATION

### Incentive Reimbursement

Incentive reimbursement experimentation was authorized by the 1967 Social Security Amendments. The objective is to explore bases of reimbursement which may, through experimentation, be demonstrated to be effective in increasing the efficiency and economy of providing health services without adversely affecting the quality of such services and which would thereby help reduce the costs of the Medicare, Medicaid and child health programs or at least retard the rate of increase. Three experiments were in actual operation at the close of fiscal 1971, and a fourth had been developed to the point that it was expected to begin shortly after the close of the year.<sup>1/</sup> Several other proposals were under active consideration.

The four operational experiments are with (1) the Connecticut Hospital Association, (2) Blue Cross of Southern California, (3) the Hospital Insurance Plan of Greater New York (HIP), and (4) Maryland Blue Cross. Each experiment is designed to test a valid theory of cost containment: (1) incentives through peer review in Connecticut; (2) incentives based on productivity standards and combined with industrial engineering assistance in Southern California; (3) the influence of group practice physicians and nurse clinicians in discharge planning in HIP; and (4) in-depth industrial and management engineering studies in Maryland. The Maryland experiment has not been operational long enough to determine either its possible effectiveness or any significant problems which might exist. From the other experiments, however, some tentative conclusions have been drawn and are now under consideration:

#### 1. The Connecticut experiment seems to indicate that:

- neither of the two principal assumptions of peer review (that hospital personnel would be more knowledgeable about hospital affairs and would tend to be more critical and severe with their peers than laymen) is necessarily true;
- large hospitals do not seem to respond to cash incentives as readily as smaller hospitals;
- the budgeting process in hospitals generally needs major improvements; and
- it will be technically difficult to develop an acceptable methodology for retrospectively adjusting target budgets for differences between actual and estimated volume.

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<sup>1/</sup> By the close of fiscal 1972, four experiments were in operation and a fifth was scheduled to begin July 1, 1972. The fifth experiment is being conducted by the Birmingham Regional Hospital Council.

2. Some of the problems highlighted by the California experiment are similar to those in Connecticut. In neither experiment has the prospect of cash incentives had the effect on the hospitals that was expected. In California, however, this does not seem to be related to hospital size, for some of the larger hospitals have shown interest in earning incentive rewards. A general decline in occupancy in the Southern California hospitals during the period of the experiment seems to have adversely affected productivity, possibly because of hospitals' reluctance to release skilled staff which would be difficult to replace if it is needed later. The experiment has also indicated that competition among hospitals for both patients and medical staff has a definite influence on the decision-making process.

#### Prospective Rate Determination

Concern about the inadequacies of retroactive reasonable cost determinations continued to grow during the year. Both the Department and the Congress are aware of the advantages which alternative methods of reimbursement might yield and have been exploring approaches which might both support our efforts to curb inflation of health care costs and introduce incentives and more effective controls on the cost determination process. Prospective rate determination seems to be one of the most promising approaches. Unlike retrospective cost reimbursement, it would require that the rate of payment be set in advance of the period to which it would apply. If actual costs are less than the prospective rate, the provider would retain all or part of the resultant savings. If actual costs exceed the prospective rate, the provider would bear the loss. It would be expected that providers would institute cost savings measures to stay within the known reimbursement rate and to participate in any savings. Deficiencies in cost data and limitations in current methodologies for comparing costs among providers, measuring health care output, and estimating costs necessary for efficient delivery of health care are among the problems we can expect to encounter in trying to make prospective reimbursement work. 2/

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2/ Considering the important implications of such a change, Congress in the 1967 Social Security Amendments indicated its support for experimentation with alternative approaches to prospective reimbursement. To increase our capability to control costs while such experiments are underway, both H.R. 17550 (91st Congress) and H.R. 1 (92nd Congress) would authorize establishment of prospective limits on reasonable costs under the present incurred cost approach. The limits would be based upon estimates of costs necessary for efficient patient care. Since limits would be defined in advance, providers could avoid incurring costs above acceptable levels. The President signed H.R. 1 into law on October 30, 1972.

## X. REIMBURSEMENT FOR PHYSICIANS' SERVICES

Physicians' services are reimbursed under Part B of Medicare on the basis of reasonable charges determined by taking into consideration a physician's customary charge for a given service and prevailing charges among physicians in the area for a given service. Prevailing charges set the outer limit on Medicare reasonable charge reimbursement subject only to the further limitation that reasonable charges may not exceed the charges applicable under comparable circumstances to the policyholders and subscribers of the carriers for comparable services. To a great extent, therefore, reasonable charge determinations made by Medicare are responsive to the fee-charging patterns established by the medical community.<sup>1/</sup>

Regulations were revised as of December 31, 1970 to provide that the carrier's prevailing charge screens be set at the beginning of each fiscal year at a level no higher than the 75th percentile of the customary charges, weighted by frequency, made for services during the preceding closed calendar year. This change was consistent with legislation proposed in both the 91st (H.R. 17550) and 92nd (H.R. 1) Congresses. By the end of the year, virtually all carriers had developed the required methodology and prevailing charge screens.

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1/ Instructions were issued to the Medicare carriers and put into effect to implement both Phase I and Phase II of the President's economic stabilization program. Because of a ruling by the Price Commission, only 40 percent of the calculated increases in allowable charge levels can be recognized for the 12-month period beginning July 1, 1972.

The ruling of the Price Commission is that the Medicare allowable charges in effect on November 13, 1971, must be considered as base prices for Phase II purposes, and that, as a result, they may not be increased by more than 2.5 percent in the aggregate during the fiscal year beginning July 1, 1972. Based on actual increases in physician and supplier billings in calendar year 1971, the charges allowed under the Medicare program for the 12-month period beginning July 1, 1972, would have been increased by about 6.2 percent in the aggregate. To implement the Price Commission's ruling, therefore, only 40 percent (2.5 is about 40 percent of 6.2) of the increases that would ordinarily have been allowed will be recognized in calculating allowable charges for the fiscal year beginning July 1, 1972. The instructions also provide that where it has come to a carrier's attention that a 1971 charge reflects a price increase that was made contrary to the Phase I guidelines or Phase II regulations of the Price Commission, the charge may not be used in calculating the new fee screens.

APPENDIX A

## SUMMARY DATA ON MEDICARE OPERATIONS

### Beneficiaries

The number of persons entitled to hospital insurance increased to 20.7 million on July 1, 1971, a gain of 381,000 over the total as of July 1, 1970 and a figure which includes nearly every American age 65 and over.<sup>1/</sup>

On July 1, 1971, the number of persons enrolled for medical insurance reached 20.0 million, representing a 390,000 increase from the 19.6 million enrolled on July 1, 1970. Over 95 percent of the aged population entitled to hospital insurance was enrolled for medical insurance.

### Health Care Resources

At the close of fiscal 1971, there was a net decrease of 31 participating hospitals from the total at the end of fiscal 1970, bringing the number of hospitals participating in the Medicare program on June 30, 1971 to 6,745. Among participating hospitals were 6,315 general and specialty hospitals, down 15 from last year; 335 psychiatric hospitals, down 7 from last year; and 95 tuberculosis hospitals, down 10 from last year. The total number of beds in hospitals participating in Medicare decreased by nearly 11,000 to 1,188,000.

At the end of fiscal 1971, there were 4,287 participating extended care facilities with 307,500 beds--a decrease of 369 ECF's and 26,000 beds under the totals a year earlier. The number of beds represents about two-fifths of the Nation's skilled nursing beds in nonhospital facilities.

A total of 2,284 home health agencies were certified to participate in Medicare on June 30, 1971--a decrease of 66 agencies during the 12-month period. About three-fifths of the agencies provide visiting nurse care and two or more additional services, while two-fifths offer the basic requirement of visiting nurse care and one additional service.

Independent laboratories approved for Medicare at the end of fiscal 1971 numbered 2,751--an increase of 67 over the previous year's total.

Since July 1, 1968, physical therapy services have been covered when furnished on an outpatient basis by, or under the supervision of, qualified "providers of service." In addition, of course, physical therapy has been covered since the start of the program when furnished

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<sup>1/</sup> Excluded from coverage are certain Federal employees covered under the Federal Employees Health Benefits Act, aliens admitted for permanent residence but not residing in the United States for 5 consecutive years preceding their application for hospital insurance entitlement, and persons convicted of crimes against the United States. Included in the total are 176,000 beneficiaries residing in foreign countries and persons living in Puerto Rico and United States territories and possessions.

in physicians' offices or as part of covered home health services. At the end of fiscal 1971, a total of 113 clinics, rehabilitation agencies and public health agencies--compared to 107 a year earlier--had been certified to participate as outpatient physical therapy providers in addition to participating hospitals, extended care facilities and home health agencies.

The following table summarizes the changes which have occurred in participating facilities

Type of Facility	Facilities		
	July 1970	July 1971	Percent Change
Hospitals <sup>2/</sup> .....	6,776	6,745	-.5
General .....	6,330	6,315	-.2
Psychiatric .....	341	335	-1.8
Tuberculosis .....	105	95	-9.5
Extended care facilities ...	4,656	4,287	-7.9
Home health agencies .....	2,350	2,284	-2.8
Independent laboratories ...	2,684	2,751	+2.5

Type of Facility	Beds		
	July 1970	July 1971	Percent Change
Hospitals <sup>2/</sup> .....	1,199,030	1,188,013	-.9
General .....	856,609	868,322	+1.4
Psychiatric .....	320,709	300,696	-6.2
Tuberculosis .....	21,712	18,995	-12.5
Extended care facilities ...	333,630	307,548	-7.8
Home health agencies .....	---	---	---
Independent laboratories ...	---	---	---

<sup>2/</sup> Excludes 17 Christian Science sanatoriums

### Benefit Payments

In Medicare's fifth year, the program paid \$5,443 million in benefits under the hospital insurance program compared to \$4,804 million during the fourth year. Medical insurance benefits paid amounted to \$2,035 million, up from \$1,979 million paid in fiscal 1970.

An analysis of hospital insurance claims approved for payment in fiscal 1971 and recorded in SSA records shows that inpatient hospital services accounted for 86.2 percent of paid claims, but 95.4 percent of total disbursements. The respective percentage figures for other services were: extended care 6.9 percent of claims and 3.8 percent of disbursements; posthospital home health services 6.9 percent of claims and 0.8 percent of disbursements.

A breakdown of medical insurance claims approved for payment in fiscal 1971 and recorded in SSA records indicates that physicians' services accounted for 82.9 percent of paid claims, and 90.2 percent of total disbursements. For other services, the respective percentage figures were: outpatient hospital services 9.6 percent of claims and 4.8 percent of disbursements; other medical services and supplies 4.1 percent of claims and 3.3 percent of disbursements; home health care 0.8 percent of claims and 1.0 percent of disbursements; and independent laboratory services 1.9 percent of claims and 0.6 percent of disbursements. In fiscal 1971, excluding claims from hospital-based physicians, 60.1 percent of the claims submitted for physician services were assigned. The total assignment percentage, including hospital-based physicians, was 63.9 percent.

Charges were reduced on 29.5 percent of approved claims processed by carriers in fiscal 1970 and on 46 percent of approved claims processed in fiscal 1971, excluding hospital-based physicians. The average dollar amount of reduction per reduced claim was \$12.50 in fiscal 1971 and \$16.90 in fiscal 1970. Total reductions on approved claims, excluding hospital-based physicians, were \$183 million in fiscal 1970 and \$241 million in fiscal 1971.

### Inpatient Hospital Services

During Medicare's fifth fiscal year, there were more than 6.2 million covered hospital admissions, up about 90,000 admissions over fiscal 1970. The fiscal 1971 total represented an annual average of 305 admissions to short and long-term hospitals for every 1,000 persons covered under the program, a slight decrease from the previous year's rate of 307.

In fiscal 1971, a total of 4,439 claims for emergency hospital services were processed--a decrease of 5,500 claims from the preceding year. About 47 percent were allowed, compared to 44 percent last year, while 53 percent were either wholly or partially denied.

For the year ended June 30, 1971, hospitals were paid an estimated \$5.1 billion for inpatient hospital services, an increase of about \$700 million over the preceding 12 months. Reimbursement averaged \$760 per recorded inpatient hospital bill; the comparable figure for the previous year was \$691.

#### Extended Care Services

During fiscal 1971, there were 417,400 admissions to extended care facilities, down from 473,800 the previous year and an annual rate of 20.4 per 1,000 persons covered, compared to 23.7 per 1,000 in fiscal 1970. There was about one extended care facility admission for covered posthospital care, on the average, for every 15 hospital admissions.

An estimated \$247 million was paid to extended care facilities during the fiscal year for extended care services. Reimbursement averaged \$375 per recorded extended care bill compared to \$364 in fiscal 1970.

#### Home Health Services

There were 244,400 "start of care" notices for home health services under both the hospital insurance and medical insurance programs in fiscal 1971, a decrease of about 52,000 under the previous year. The total amounted to 12 notices per 1,000 persons covered, compared to 15 per 1,000 the previous year.

During fiscal year 1971, an estimated \$101 million was paid for home health services, up from \$96 million in fiscal 1970. The average payment per recorded bill was \$84 under hospital insurance and \$53 under medical insurance, compared to \$78 and \$53 respectively in the preceding 12-month period.

#### Outpatient Hospital Services

In fiscal 1971, 4.6 million outpatient hospital bills--both diagnostic and therapeutic--were reimbursed under Medicare, up from over 3.8 million during the previous 12 months. Total payments to hospitals for covered outpatient services were estimated at \$120 million, up from \$91 million in fiscal 1970.

### Physicians' Services

In fiscal 1971, a total of 36.4 million bills for physicians' services were approved for payment and recorded in Social Security Administration records, in comparison to 32.7 million bills in fiscal 1970. Of the fiscal 1971 bills, 15.0 percent were for surgical services and 85.0 percent for medical services. Reasonable charges for surgical bills amounted to \$891 million and averaged \$163 per bill (fiscal 1970 figures were \$766 million and \$163 respectively); for medical bills, this amounted to \$1.43 billion and averaged \$47 per bill (in fiscal 1970, the amounts were \$1.38 billion and \$49, respectively).

For physicians' surgical services, the proportion of reasonable charges reimbursed by Medicare was 75.6 percent. For physicians' medical services, the comparable proportion was 71.5 percent.

### Other Medical Services and Supplies

There were 2.6 million paid bills recorded for nonphysician medical services, other than home health and outpatient hospital services, in fiscal 1971--up from 2.3 million in the preceding fiscal year. The average reasonable charge per bill for independent laboratory services was \$18, compared to \$19 a year earlier, while the figure for "other medical services" was \$48 in fiscal 1971 (\$50 in fiscal 1970). Included in the "other" category are rental or purchase of durable medical equipment, ambulance services, prosthetic devices, and certain other medical services and supplies.

APPENDIX B

# Five Years of Medicare—A Statistical Review

by HOWARD WEST\*

THE 1965 AMENDMENTS to the Social Security Act added—as part of the social insurance protection provided under the Act—two coordinated programs of health insurance for the aged, familiarly known as Medicare. On July 1, 1966, a basic hospital insurance plan (HI) and a voluntary supplementary medical insurance plan (SMI) went into effect. The Medicare program was designed to provide the financial means to help older people pay a major portion of their large bills for hospital and medical care. The amounts paid by the beneficiary are shown in table 1.<sup>1</sup>

In the ensuing 5 years, the extent to which Medicare has succeeded in accomplishing its primary purpose has been obscured by growing national concern with the rapid increases in the cost of all forms of medical care and with the degree of efficiency with which medical care services are delivered. This article attempts to enlarge the parameters by focusing on the experience of the aged under Medicare reflected by the currently available data on the utilization of medical care services and on related reimbursement patterns.

## THE STATISTICAL SYSTEM

The administration of these two coordinated programs of benefits for the aged generates a variety of data needed to measure and evaluate program operation and effectiveness. Benefit-payment operations furnish information about the amount and kind of hospital and medical care services used by the aged, as well as the expenditures for such services. The applications

by hospitals, extended-care facilities, home health agencies, and independent laboratories to participate in the program provide data on the characteristics of such providers of services. The enrollment process results in the identification of each aged person eligible for health insurance benefits and indicates whether he is entitled to hospital benefits, to supplementary medical insurance benefits, or to both. The claim number assigned to each individual serves as the link between the program benefits utilized and his demographic characteristics recorded in the enrollment file.

The data-collection system has two inherent characteristics that determine the scope, detail, and flexibility of the available data. First, data are collected and maintained on an individual basis so that the beneficiary and his medical experience under the program form the basic unit. Second, records of each bill paid under the program and, for a sample of beneficiaries, records of diagnoses and surgical procedures are maintained on a centralized basis.

The benefit-payment operations involve considerable delays in the reporting of utilization and related reimbursement information. Final data for services used during a given period of time do not become available until the hospital and medical bills sent to and paid by intermediaries and carriers throughout the country are received and processed by the Social Security Administration. There is no time limit on filing HI claims for reimbursement; the maximum imposed for filing SMI claims is 27 months from date of service. For this reason, a continuing monthly Current Medicare Survey (CMS)<sup>2</sup> is conducted to obtain current estimates of hospital and medical services used and charges incurred by persons covered by these two programs. The hospital insurance sample of CMS consists of a sample of all hospital admission notices, which must be sent to the Social Security Administration. The medical insurance sample is composed of a household-

\* Office of Research and Statistics, Division of Health Insurance Studies. The article is adapted from a paper presented at the 99th annual meeting of the American Public Health Association, October 13, 1971, Minneapolis, Minnesota.

<sup>1</sup> For a full description of the provisions of the health insurance program, see Wilbur J. Cohen and Robert M. Ball, "Social Security Amendments of 1965: Summary and Legislative History," *Social Security Bulletin*, September 1965; see also Robert M. Ball, "Health Insurance for People Aged 65 and Over: First Steps in Administration," the *Bulletin*, February 1966.

<sup>2</sup> See Jack Scharff, "Current Medicare Survey: The Medical Insurance Sample," *Social Security Bulletin*, April 1967.

TABLE 1.—Medicare cost-sharing and premiums

Beginning—	Hospital benefits in benefit period			Outpatient hospital diagnostic services		Supplementary medical			
	Inpatient hospital deductible	Inpatient hospital daily coinsurance		Extended-care facility daily coinsurance after 20 days	Deductible	Coinsurance	Annual deductible	Coinsurance	
		After 60 days	After 90 days						
July 1966.....	\$40	\$10	(1)	(1)	\$20	20%	\$50	20%	\$3.00
January 1967.....			(1)	\$20					
January 1968.....									
April 1968.....									
January 1969.....	44	11	22	5.50			(4)	(4)	4.00
January 1970.....	52	13	26	6.50					
July 1970.....									5.30
January 1971.....	60	15	30	7.50					
July 1971.....									5.60

<sup>1</sup> Benefit not provided.<sup>2</sup> Deductible applied to supplementary medical deductible.<sup>3</sup> Transferred to supplementary medical.<sup>4</sup> Professional inpatient services of pathologists and radiologists not subject to deductible or coinsurance.

<sup>5</sup> Beginning January 1972, the deductible for inpatient hospital benefits is to be \$68. The coinsurance payment for stays from the 61st to the 90th day in a hospital will be \$17 a day; after 90 days, it will be \$34 daily. The payment for the 21st through the 100th day in an extended-care facility will be \$8.50 a day.

interview sample of persons enrolled in the SMI program. The Current Medicare Survey is the source for much of the data for this article.

## THE ENROLLED POPULATION

When the Medicare program began operations on July 1, 1966, nearly all persons aged 65 and over—some 19.1 million—were entitled to HI benefits. About 17.7 million persons, or 93 percent of those entitled to HI benefits, also voluntarily enrolled in the SMI program. By July 1, 1970, the most recent date for a midyear enrollment figure, 20.4 million persons were entitled to HI benefits, and 19.6 million, or 96.2 percent of those entitled to HI coverage, had enrolled for SMI benefits. There is some evidence from the Current Medicare Survey that a substantial portion of the increase in the proportion of HI enrollees electing to receive SMI benefits are persons who enrolled in the medical insurance program following an illness that required the use of HI benefits.

The race and sex distributions of enrollees in both HI and SMI have remained about the same since Medicare began. The median age of the Medicare population has been fairly constant: it was 72.8 in 1966 and 73.0 on July 1, 1970. The median age of white women (73.3) and that of white men (72.5) each exceeded the median of all other races by slightly over one-half year. Table 2 shows the age, race and sex, and region of residence of persons on the rolls of the HI

program as of July 1, 1966, and July 1, 1970.

Tabulations of the populations enrolled in the HI and the SMI programs serve as the base for utilization and reimbursement rates. For most purposes the enrollment as of the midpoint of the calendar year is used (October 1 for the

TABLE 2.—Number and percentage distribution of persons enrolled for hospital insurance, by age, race, sex, and region of residence, July 1, 1966, and July 1, 1970<sup>1</sup>

Age, race and sex, and area of residence	Number enrolled as of July 1 (in thousands)		Percentage distribution	
	1970	1966	1970	1966
<b>Age:</b>				
65 and over.....	20,361	19,082	100.0	100.0
65 and 66.....	2,826	2,749	13.9	14.4
67 and 68.....	2,700	2,529	13.3	13.3
69 and 70.....	2,484	2,434	12.2	12.8
71 and 72.....	2,225	2,257	10.9	11.8
73 and 74.....	2,081	2,022	10.2	10.6
65-69.....	6,779	6,507	33.3	34.1
70-74.....	5,537	5,483	27.2	28.7
75-79.....	4,140	3,769	20.3	19.8
80-84.....	2,438	2,140	12.0	11.2
85 and over.....	1,467	1,183	7.2	6.2
<b>Race and sex:</b>				
All persons.....	20,361	19,082	100.0	100.0
Men.....	8,507	8,133	41.8	42.6
Women.....	11,855	10,950	58.2	57.4
White.....	18,187	17,042	89.3	89.3
Men.....	7,610	7,357	37.4	38.6
Women.....	10,577	9,685	51.9	50.8
All other races.....	1,608	1,445	7.9	7.6
Men.....	715	656	3.5	3.4
Women.....	894	789	4.4	4.1
Race unknown.....	566	506	2.8	3.1
Men.....	182	120	.9	.6
Women.....	384	476	1.9	2.5
<b>Residence:</b>				
All areas.....	20,361	19,082	100.0	100.0
United States <sup>2</sup> .....	20,015	18,708	98.3	98.5
Northeastern States.....	5,202	5,021	25.5	26.3
North Central States.....	5,750	5,548	28.2	29.1
South.....	5,966	5,402	29.3	28.3
West.....	3,087	2,813	15.2	14.7

<sup>1</sup> Figures for 1966 based on final data recorded Dec. 29, 1967; figures for 1970 based on provisional data recorded Mar. 31, 1971.

<sup>2</sup> Includes enrollees with residence unknown.

period July–December 1966). Because of the high mortality of the Medicare population, the mid-year figure is approximately 6 percent below the figure for persons enrolled at any time during a calendar period. The “ever-enrolled” population is used for selected analyses of differentials in utilization.

## THE PROVIDERS

All hospitals, extended-care facilities, home health agencies, and independent laboratories participating in the Medicare program must be in substantial compliance with the conditions of participation.<sup>3</sup> The great majority of hospitals in the United States have participated in the hospital insurance program since it began. The number of short-stay hospitals remained essentially constant and the number of available beds has increased over the 5-year period (table 3).

TABLE 3.—Number of participating hospitals, and number of beds, by type of hospital, all areas, 1966–71

Year	All hospitals	Short-stay	All long-stay	Tuberculosis	Psychiatric	Other long-stay
Hospitals						
Dec. 31, 1966	6,790	6,160	630	117	320	193
July 1, 1967	6,857	6,217	640	120	331	189
July 1, 1968	6,865	6,224	641	118	341	182
July 1, 1969	6,825	6,182	643	113	344	186
July 1, 1970	6,776	6,153	623	105	341	177
July 1, 1971	6,745	6,153	592	95	335	162
Beds						
Dec. 31, 1966	1,149,601	758,282	391,409	23,947	312,950	54,512
July 1, 1967	1,157,603	770,369	387,234	23,474	322,886	40,874
July 1, 1968	1,164,931	782,802	382,129	23,903	318,896	39,330
July 1, 1969	1,176,656	798,652	378,004	23,263	313,519	41,222
July 1, 1970	1,199,030	815,244	383,786	21,712	320,709	41,365
July 1, 1971	1,188,013	834,514	353,499	18,995	300,696	33,808

The ratio of all short-stay hospital beds to the enrolled HI population for the United States was approximately 40 per 1,000 throughout the period. The greatest increase in the number of beds took place in the South where hospitals that initially were not in compliance with title VI of the Civil Rights Act of 1964 and had “spe-

<sup>3</sup> Social Security Administration, *Conditions of Participation, Hospitals: Federal Health Insurance for the Aged, Regulations* (HIR-10); *Conditions of Participation, Extended-Care Facilities . . .* (HIR-11); *Conditions of Participation: Home Health Agencies . . .* (HIR-12); *Conditions for Coverage of Services of Independent Laboratories . . .* (HIR-13).

cial certification” have agreed to provide services on a nondiscriminatory basis.

Changes in the number of participating extended-care facilities and the number of beds in these facilities since this benefit was first available in 1967 have been relatively greater than in the number of hospitals and hospital beds. A peak was reached in 1969 when there were 4,849 facilities with a total of 341,735 beds (table 4). By July 1, 1971, the number of facilities was 4,287, with 307,548 beds certified for participation in the program: 12 percent fewer than in 1969 and providing 10 percent fewer beds. In part the decline has been due to increased efforts to assure that payment is made only for services to patients requiring skilled nursing services for medical conditions that were under treatment in the hospital before admission to the facility. These efforts brought about a decrease in the number of patients eligible for such care and a commensurate decrease in the need for such beds.

TABLE 4.—Number of participating extended-care facilities and number of beds, all areas, 1967–71

Year	Facilities	Beds
1967	4,160	291,307
1968	4,702	321,621
1969	4,849	341,735
1970	4,656	333,630
1971	4,287	307,548

## EXPENDITURES AND PRICES

### Medicare Trust Funds

Medicare outlays from the two trust funds established for this program amounted to \$7.9 billion in fiscal year 1971,<sup>4</sup> an increase of 10.2 percent over the expenditures for the previous fiscal year. These outlays averaged \$380 per person aged 65 and over enrolled in the hospital and/or medical insurance programs (table 5).

The first 5 years of Medicare witnessed significant increases in expenditures each year, which rose from \$3.4 billion in the first year to the current annual level of \$7.9 billion. Under

<sup>4</sup> 1971 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (93d Cong., 1st sess., House Document No. 92-87); 1971 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (House Document No. 92-89).

TABLE 5.—Total and per capita hospital and medical insurance expenditures, fiscal years 1967–71

Program	Fiscal year				
	1967	1968	1969	1970	1971
Amount (in millions)					
Hospital and medical insurance	\$3,395	\$5,347	\$6,598	\$7,149	\$7,475
Benefit payments	3,172	5,126	6,299	6,784	7,478
Administrative expenses	223	221	299	366	397
Hospital Insurance	2,597	3,815	4,757	4,953	5,592
Benefit payments	2,508	3,736	4,654	4,804	5,443
Administrative expenses	89	79	104	149	149
Medical insurance	798	1,532	1,840	2,196	2,283
Benefit payments	664	1,390	1,645	1,979	2,035
Administrative expenses	134	143	195	217	248
Per capita amount					
Hospital and medical insurance	\$178	\$274	\$333	\$353	\$380
Benefit payments	166	263	318	335	361
Administrative expenses	12	11	15	18	19
Hospital Insurance	136	196	241	246	272
Benefit payments	131	192	236	238	265
Administrative expenses	5	4	5	7	7
Medical insurance	# 45	85	98	114	116
Benefit payments	37	77	87	102	103
Administrative expenses	8	8	10	11	13
Percentage change from preceding fiscal year					
Hospital and medical insurance	57.5	23.4	8.4	10.2	
Benefit payments	61.6	22.9	7.7	10.2	
Administrative expenses	-6	35.1	22.4	8.6	
Hospital insurance	46.9	24.7	4.1	12.9	
Benefit payments	49.0	24.6	3.2	13.3	
Administrative expenses	-11.5	32.5	42.7	.6	
Medical insurance	92.0	20.1	19.4	3.9	
Benefit payments	109.2	18.4	20.3	2.8	
Administrative expenses	6.7	36.5	11.5	14.1	

HI, the total increased from \$2.6 billion in the first year to \$5.6 billion in the fifth year. The average per enrollee in 1971 was \$272—exactly double the 1967 average. Under SMI, expenditures almost tripled—from about \$800 million in fiscal year 1967 to almost \$2.3 billion in fiscal year 1971. The SMI average per enrollee rose from \$45 to \$116. Included in these figures are benefit payments and administrative expenses.

The experience for these 5 years shows considerable variation in the annual rates of increase for each part of the program. More important, a significant slowing down is apparent in the rate of increase during the past year or two.

Medicare outlays in the program's first year were relatively low compared with those for the later years, primarily because of the considerable lag in the program's early days before bills were submitted and processed for reimbursement. Other factors contributing to the substantially

lower figures for the first year were the availability of extended-care benefits for only half the year (January–June 1967) and the application of the entire \$50 deductible under the SMI program for only a 6-month period in calendar year 1966 (except for the carryover provision).<sup>5</sup>

The annual increases in total and average reimbursements also reflect the increases in prices and utilization, analyzed below for the two programs.

*Hospital insurance program.*—During the past 3 years, the annual rate of increase in HI benefit payments has fluctuated to a considerable extent—25 percent in fiscal year 1969, 3 percent in fiscal year 1970, and 13 percent in fiscal year 1971. The comparison is somewhat distorted, however, by a transfer of \$85 million from the SMI trust fund to the HI trust fund during fiscal year 1970 that covered expenses incurred in earlier years. Without the transfer the increase would have been 23 percent in 1969, 7 percent in 1970, and 10 percent in 1971. Several factors account for the deceleration in HI benefit payments in fiscal year 1970 and the continued relatively moderate rate of increase in fiscal year 1971:

1. Sufficient time may have elapsed since the program began to permit persons aged 65 and over to catch up with their medical care needs.
2. The occurrence of influenza epidemics in the winter months and unusual heat spells in the summer months can cause fluctuations in hospital use for the population aged 65 and over. Data from the National Communicable Disease Center show that no major epidemics occurred in fiscal year 1970 and 1971, but there were epidemics in the 2 previous years, as measured by the total number of deaths.
3. During the past 2 years the average length of hospital stay for persons aged 65 and over has declined by almost one day.
4. Controls on the use of extended-care facilities under Medicare were tightened. The result was a reduction in expenditures for this purpose from \$367 million in fiscal year 1969 to \$295 million in the following year; in fiscal year 1971, expenditures continued to decline and dropped to \$247 million.
5. Cost factors also contribute to changes in rates of Medicare spending. A 2-percent special allowance in the hospital reimbursement formula was removed in fiscal year 1970. (On July 2, 1971, the Social Security Administration issued new regulations for determining the inpatient routine nursing-salary cost differential as an element of reimbursable

<sup>5</sup> The carryover provision permits any expenses incurred in the last 3 months of the calendar year and applied to the deductible for that year to be carried over and applied to the deductible for the next calendar year.

cost under the HI program. The adjustment factor is to be applied to cost reporting periods beginning July 1, 1969, and will be applied retroactively. This adjustment is therefore not reflected in the expenditures for fiscal years 1970 and 1971.)

Throughout the 5-year period, hospital costs per patient day have continued to rise at relatively high annual rates as the data from two sources indicate: the hospital daily service charges component of the Consumer Price Index of the Bureau of Labor Statistics and expenses per patient day as reported by the American Hospital Association. The fiscal year averages and annual percentage increases are shown in table 6.

*Medical insurance program.*—The fifth year of Medicare saw a sharp decline in the acceleration of the rate of spending under the SMI program. In the 2 previous years, the annual rate of increase was about 20 percent. By contrast, benefit payments in fiscal year 1971 rose only 2.8 percent. As mentioned earlier, the comparison is distorted somewhat by the transfer of \$85 million from the SMI trust fund to the HI trust fund during fiscal year 1970 that covered expenses incurred in earlier years. Without that transfer the 1970 increase would have been 10.5 percent and that for 1971, 7.4 percent.

Physicians' fees, according to that component of the Consumer Price Index, have continued to increase. In fiscal year 1971 they went up at an annual rate of 7.5 percent, as shown below.

Fiscal year	Physicians' fees (index, calendar year 1967=100)	Percentage increase
1967	96.9	7.4
1968	102.8	6.1
1969	109.1	6.1
1970	117.0	7.2
1971	125.8	7.5

It is clear that the reduction in the rate of increase in SMI benefit payments shown in table 5 is the result of the tightening of the regulations related to reimbursement of physicians' services under Medicare.

In December 1970, the Secretary of Health, Education, and Welfare announced that carriers may in each fiscal year recognize only those charges that fall within the 75th percentile of the customary charges (weighted by frequency) made for similar services in the calendar year

TABLE 6.—Consumer price index and American Hospital Association data for hospital expenses, each fiscal year, 1967-71, and annual percentage increases

Fiscal year	Hospital daily service charges		Hospital expenses per patient day (AHA)	
	Index (calendar year 1967=100)	Annual percentage increase	Amount	Annual percentage increase
1967	92.2	16.6	\$53.67	12.5
1968	106.4	15.4	61.73	15.0
1969	120.5	13.3	70.13	13.6
1970	135.4	12.4	80.71	15.1
1971	152.8	12.9	91.37	13.2

Source: Data for daily service charges are from the *Consumer Price Index*, Bureau of Labor Statistics; data for hospital expenses per patient day are from "Hospital Indicators," *Hospitals*, Journal of the American Hospital Association.

preceding the start of the fiscal year in which the determination is made. Thus, increases in prevailing charges recognized by the carriers beginning in January 1971 were limited to the levels established by the 75th percentile of calendar year 1969 customary charges.

There is evidence from the administrative data that carriers have enforced the regulations. In fiscal year 1971, for example, charges for 19.2 million claims, or 41 percent of all claims approved, were reduced by the carriers. The amount reduced totaled \$241.2 million or 11 percent of the covered charges billed by physicians.

## THE TRANSITION, 1965 TO 1967

To measure the early effects of Medicare on the health care of the aged, comprehensive baseline data were needed. Early in 1966, the Social Security Administration contracted with the Columbia University School of Public Health and Administrative Medicine and with the National Opinion Research Center of the University of Chicago to conduct a two-part survey. The survey was designed to determine patterns in use of hospital and medical care by the aged and in charges for such services—both before and after the implementation of Medicare.<sup>6</sup> Interview questions were designed to produce information on hospital and medical care utilization and charges during the year before the date of the interview. For the first phase, the period covered was April-May 1965 to April-May 1966. For the second

<sup>6</sup> Regina Loewenstein, "Early Effects of Medicare on the Health Care of the Aged," *Social Security Bulletin*, April 1971.

phase, the period studied was November–December 1966 to November–December 1967.

This two-part survey indicated that the Medicare program had gone a long way toward meeting its goal. For short-stay hospital care, the most significant change occurred in the days of care per enrolled aged person, which rose 25 percent. This increase reflects primarily the longer hospital stays but also reflects an increase in hospital use. Much greater increases occurred for certain segments of the aged population, including persons aged 75 and over, Negroes, residents of the South, persons residing in urban areas other than metropolitan areas, and persons in one-member family units with low incomes.

Before Medicare, for a substantial proportion of hospital stays—17 percent—no charges were incurred; under Medicare this proportion was reduced to 3 percent. The rate of hospital days with charges incurred rose 50 percent but doubled for persons aged 75 and over and for Negroes. The proportion of total hospital charges paid directly by the patient declined from 38 percent to 7 percent, in spite of rising prices, more stays with charges incurred, and a doubling of average hospital charges per person between the two survey periods.

The use of long-term medical institutions did not change with the introduction of Medicare, but there was a shift from the use of nursing homes to using extended-care facilities, which are covered under the program and provide a higher level of skilled nursing care. In contrast to the short-stay hospital experience, in extended-care facilities both the number of days of care per aged person and the average length of stay declined under Medicare. The former nursing homes that were certified as extended-care facilities under Medicare admitted mainly convalescent patients requiring short-term skilled nursing care, while places continuing as nursing homes cared for the long-term patients.

No significant changes occurred in the proportion of persons using ambulatory medical services, and a slight decrease was noted in the number of reported visits per person. There was, however, a shift from clinic and home visits to office visits.

The introduction of Medicare apparently had no effect on the average charges for those services not covered by the program. No changes were reported, for example, in the average charges

per aged person for drugs, dental care, and optometrists.

The total impact of the program during the survey period in providing protection for the aged against the high costs of health care is revealed when all institutional, medical, and other charges, whether or not covered under Medicare, are combined. These average charges increased about 40 percent—from \$298 per person to \$418—because of the larger proportion of stays and visits with charges, more days in short-stay hospitals, and higher charges for institutional and medical services in the later year. Almost half the charges incurred in 1967 were paid for by the Medicare program, and about 6 percent were paid by private health insurance. Thus 47 percent of the total remained to be paid directly—a significant reduction from the 77 percent paid directly in 1965, before Medicare. The substantial rise in the level of charges per person, however, resulted in a decline of only 15 percent in out-of-pocket payments for all health care services.

The immediate impact of the Medicare program on the utilization of covered services, as delineated by this two-part survey, bears repeating.

- Short-stay hospital use rose 25 percent, measured by days of care per enrolled aged person.
- In-patient medical services increased commensurately.
- Use of long-term medical institutions did not change but shifted from nursing homes that were not covered under Medicare to extended-care facilities that were covered.
- The proportion of persons using ambulatory medical services remained the same and the number of such visits per person declined slightly.

## UTILIZATION AND REIMBURSEMENT UNDER MEDICARE

What has been the subsequent utilization experience under Medicare? Two sources of information are available that describe hospital utilization by the aged during the 5-year period July 1, 1966–June 30, 1971: (1) data on claims approved for payment under the HI program and recorded in social security records; (2) data on hospital use reported by the American Hospital Association in the midmonth issue of *Hospitals*.

Medicare claims data include all covered hos-

TABLE 7.—Hospital utilization under Medicare, all covered stays, fiscal years 1967-71

Fiscal year	Admissions		Covered days of care		Average length of stay <sup>2</sup>
	Number (in thousands)	Rate per 1,000 enrollees <sup>1</sup>	Number (in thousands)	Rate per 1,000 enrollees <sup>1</sup>	
1967.....	5,209	278	61,682	3,232	12.2
1968.....	5,774	297	75,400	3,874	13.1
1969.....	6,067	307	81,000	4,101	13.1
1970 <sup>3</sup> .....	6,135	306	79,000	3,944	12.7
1971 <sup>3</sup> .....	6,300	309	78,000	3,829	12.3

<sup>1</sup> Based on total enrollment in HI program as of January 1 each year.

<sup>2</sup> Based on bills, not discharges, and may be slightly understated.

<sup>3</sup> Estimated.

Source: Social Security Administration control records.

pital stays under the program and include stays in short- and long-stay hospitals. The data for 1970 and 1971 shown in table 7 are adjusted for lags in reporting of claims to the Social Security Administration.

From the beginning of the program, hospital admission rates per 1,000 enrollees have risen steadily: from 278 per 1,000 in fiscal year 1967 to 309 in fiscal year 1971. The rate of increase in this measure has slowed, however, from 7 percent between fiscal year 1967 and 1968 to 1 percent by 1971. Covered days of care per 1,000 enrollees increased from 3,232 in 1967 to 4,101 in 1969 but the number for the most recent fiscal year has dropped to an estimated 3,829. The decline of almost one day in average length of stay in the past 3 years is the key to the apparent inconsistency between these two rates.

The trends shown by Social Security Administration claims data are remarkably consistent with American Hospital Association figures. These data, shown in table 8, are based on discharges from a random sample of approximately 650 non-Federal short-stay hospitals registered by the American Hospital Association.

TABLE 8.—Hospital utilization, persons aged 65 and over, non-Federal, short-term general hospitals, fiscal years 1967-71

Fiscal year	Admissions		Total days of care		Average length of stay (days)
	Number (in thousands)	Rate per 1,000 aged persons <sup>1</sup>	Number (in thousands)	Rate per 1,000 aged persons <sup>1</sup>	
1967.....	5,208	275	65,918	3,480	12.7
1968.....	5,505	285	73,093	3,785	13.3
1969.....	5,904	301	78,048	3,985	13.2
1970.....	6,145	310	78,481	3,953	12.8
1971.....	6,346	314	78,938	3,909	12.4

<sup>1</sup> Based on U.S. enrollment in HI program as of January 1 each year.

Source: "Hospital Indicators," *Hospitals*, midmonth issue.

## Utilization

It is now possible to examine the utilization of covered services under Medicare in somewhat greater depth as more detailed tabulations of actual experience are becoming available.

The Medicare program provides seven types of benefits; as shown in table 9: four under the HI program and three under the SMI program. In 1967 the largest portion of total expenditures—62.7 percent—was spent for inpatient hospital services. Posthospital stays in extended-care facilities accounted for 6.5 percent. About 29 percent of reimbursement was for physician services. Only 1 percent of 1967 reimbursements under both programs was for outpatient hospital services, and a like amount went for home health services.

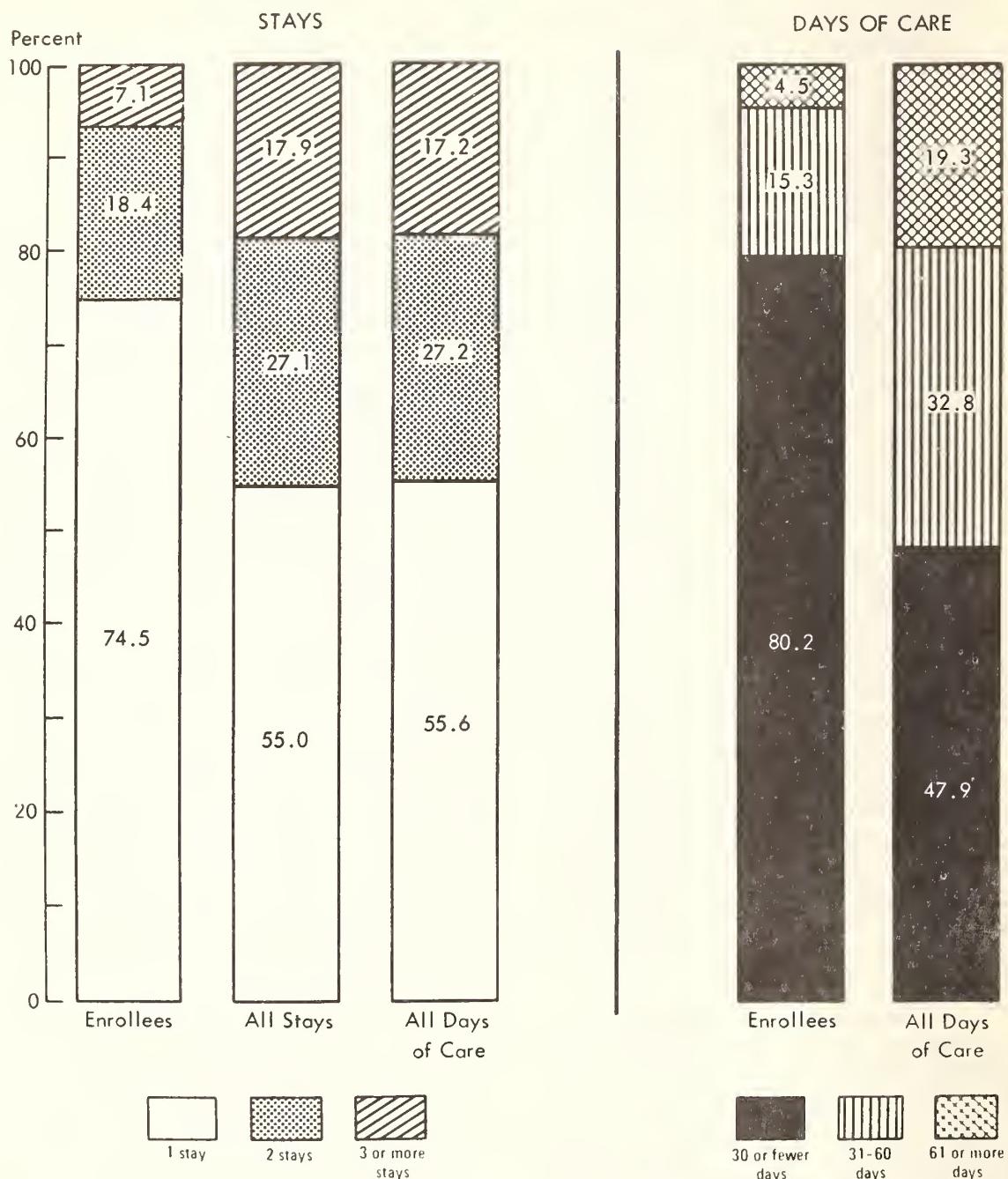
Age, race, and sex influence both the total utilization of reimbursed services and the types of services used. Utilization rates under HI increased with age, were higher for men than women, and were higher for white enrollees than for enrollees of other races. Under SMI, utilization rates for women were higher through age 79 and then slightly lower at older ages; rates for the white population exceeded those for other races to a somewhat greater extent than they did in the HI program.

Data from the Current Medicare Survey for 1968 have been used to estimate the use of Medicare services (whether or not reimbursed). About 20 percent of persons enrolled under HI at any time during 1968 used a covered HI service. The use of covered services in that year increased with age, was higher for men than for women, and was higher for white enrollees than for those of other races. Utilization rates varied slightly among the four geographic regions.

Almost all persons using covered HI services were hospitalized during the year. (A few had HI services in 1968 following hospitalization in 1967.) About 75 percent of persons hospitalized were inpatients only once during the year. The remaining 25 percent were hospitalized more than once and accounted for 45 percent of all hospital days of care (chart 1).

The average number of days of care per hospitalized enrollee (including days for which no reimbursement was made) was 19.7 in 1968, and the average number per stay was 14.5. For per-

CHART 1.—Hospital insurance enrollees hospitalized during 1968: Percentage distribution, by number of stays and days of care



sons with one, two, or three or more hospital stays, the average number of days of care was 14.7, 29.1, and 47.9, respectively. These data suggest that the average length of stay of per-

sons hospitalized more than once is about the same for their second stay or their third as it was for their first stay.

About 20 percent of hospitalized enrollees had

TABLE 9.—Persons served under Medicare and amounts reimbursed, by type of service, fiscal year 1967

Type of service reimbursed	Persons using reimbursed services			Reimbursement			
	Number (in thousands) <sup>1</sup>	Percent of persons ever enrolled	Annual rate per 1,000 enrolled, July 1, 1967	Total		Amount per person served	Amount per person enrolled, July 1, 1967
				Amount (in thousands)	Percentage distribution		
Hospital Insurance and/or supplementary medical insurance	7,154	34.5	366.5	\$4,238,633	100.0	\$592	\$217
Both hospital insurance and supplementary medical insurance	3,328	16.1	186.5	3,663,661	86.4	1,101	205
Hospital insurance only	632	3.0	32.6	286,773	6.8	454	15
Supplementary medical insurance only	3,195	15.4	178.7	288,487	6.8	90	18
Hospital Insurance	3,960	19.1	203.1	2,966,732	70.0	749	152
Inpatient hospital services	3,601	17.4	184.7	2,659,393	62.7	738	136
Outpatient hospital services	466	2.2	23.9	7,261	.2	16	-
Extended-care facilities services	354	1.7	18.2	274,295	6.5	774	14
Home health agency services	126	.6	6.5	25,783	.6	204	1
Supplementary medical insurance	6,523	31.5	364.5	1,271,901	30.0	195	71
Physician and other medical services	6,415	31.0	358.5	1,223,845	28.9	191	68
Outpatient hospital services	1,045	5.0	58.4	30,995	.7	30	2
Home health agency services	118	.6	6.6	17,061	.4	145	1

<sup>1</sup> Net count for the indicated type of service. The same person may be counted in more than one line.

Source: Social Security Administration, *Medicare—Health Insurance for the Aged, 1967, Section I: Summary* (in press).

more than 30 days of care during the year. This relatively small group of patients utilized more than 50 percent of all hospital days during 1968 (chart 1).

The utilization of extended-care facilities under the Medicare program requires a preceding stay of at least 3 days in a hospital. In 1967 a little less than 10 percent and in 1968 a little more than 10 percent<sup>7</sup> of patients discharged from a hospital one or more times during the year utilized these services at least once.

There were very large differences in the use of extended-care facilities related to age. At ages 65–74 about 5 percent of hospitalized persons used reimbursed services. The percentage increased sharply at ages 85 and over to 22 percent in 1967 and 27 percent in 1968. Women made more use of this type of benefit than men did. Of the 2 million women hospitalized in 1967, 11.6 percent were reimbursed for services in extended-care facilities; of the 1.6 million men hospitalized, 7.7 percent were reimbursed for these services.

The proportion of aged persons utilizing services under the SMI program has been remarkably stable through 1970, the most recent year for which data are available from the Current Medicare Survey. During each year from 1967 to 1970, 79 percent of the enrolled SMI population utilized SMI services (chart 2). But many of

these persons did not use sufficient services to meet the program's \$50 deductible. In 1967 about 33 percent and in 1970 about 29 percent of the population did not use more than \$50 of services; thus, just under 50 percent used sufficient covered services to be eligible for reimbursement. The proportion of persons using covered services varied with age, sex, race, and place of residence, but for each of these characteristics it has remained consistent over the entire period. A higher proportion of persons aged 85 and over (83 percent) used services than did those aged 65–74 (77 percent); the ratio was 81 percent for women and 75 percent for men; and it was essentially the same for white persons (79 percent) and for those of all other races. The percentage of persons utilizing SMI services who live in the West has been consistently slightly higher than the proportion in other geographic regions.

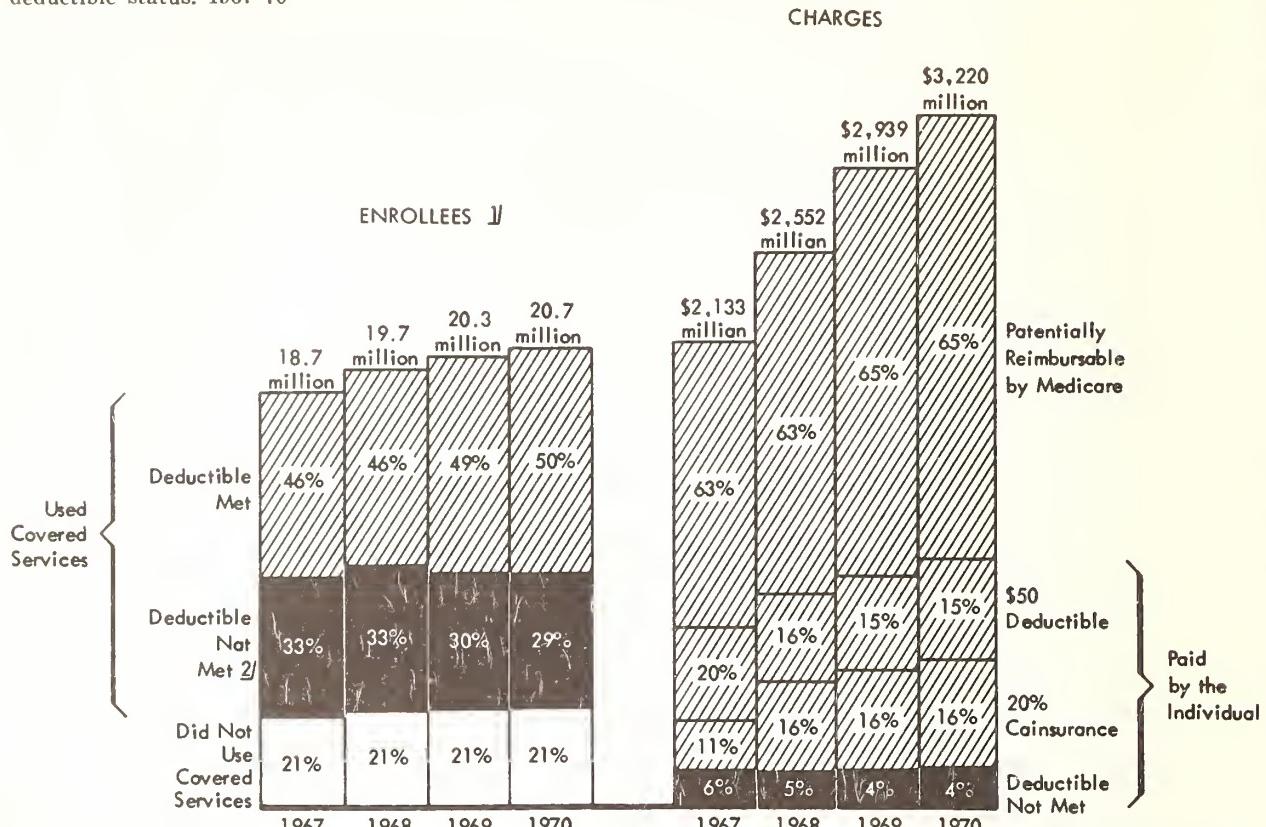
The relative size of the enrolled SMI population using ambulatory medical services, whether or not reimbursed, has been essentially constant through 1970 (table 10). Seventy percent of en-

TABLE 10.—Estimated utilization of ambulatory physician services under SMI by place of service, Current Medicare Survey, 1967–70

Place of service	Persons served per 1,000 enrolled <sup>1</sup>				Average number of visits per person using specified services			
	1967	1968	1969	1970	1967	1968	1969	1970
Office	701	688	675	667	6.3	6.2	6.5	6.5
Outpatient	172	162	172	190	2.9	3.1	3.0	3.3
Home	143	137	120	95	3.8	4.4	4.3	4.8

<sup>1</sup> The same person may be counted in more than one line.

CHART 2.—Enrollees and charges under the supplementary medical insurance program: Percentage distribution, by deductible status, 1967-70



<sup>1</sup> Annual totals represent all persons ever enrolled during the year in the supplementary medical insurance program.

<sup>2</sup> Includes persons using services for whom no bill is expected.

rollees used physician office services in 1967 and 67 percent in 1970. The average number of office visits remained constant during the period, with 6.5 visits a year, on the average, for each person using this type of ambulatory care service.

Between 1967 and 1970, the average number of outpatient visits per person using these services remained at about 3 per person. The percentage of persons obtaining physician services at home dropped sharply from 14 percent to 9.5 percent, but the average number of home visits to these patients rose from 3.8 to 4.8 between 1967 and 1970.

#### Reimbursement

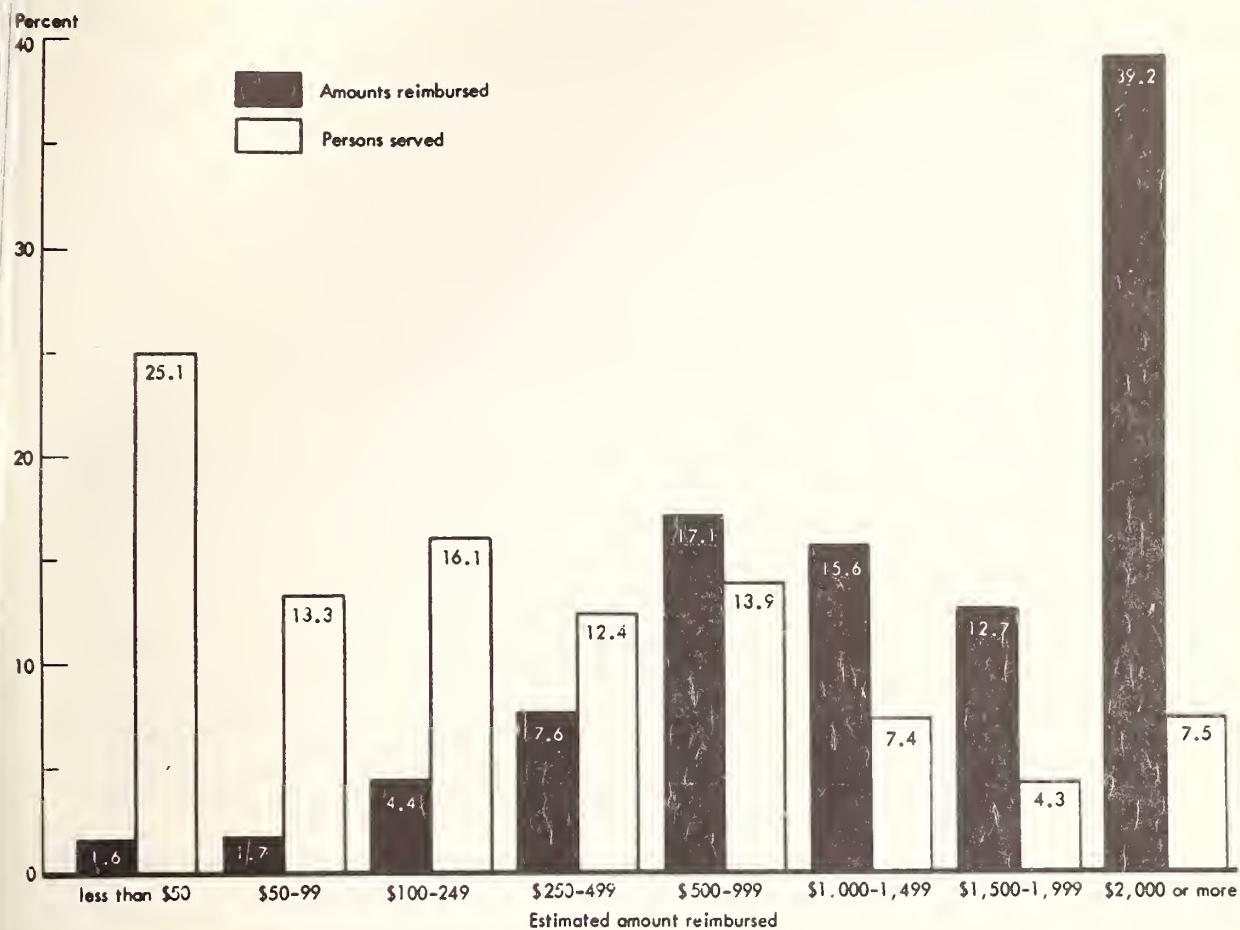
The Medicare program expenditures previously described were actual outlays for benefit payments and administrative expenses made during each of Medicare's first 5 fiscal years. Data are also available on reimbursements under the pro-

gram for covered services provided during the year for a 5-percent sample of persons enrolled in the program. For services rendered in calendar year 1967, for example, total reimbursements were \$4.2 billion. Of this total, \$3.0 billion was spent in the HI program and \$1.3 billion in SMI. The proportion of the eligible population receiving some reimbursement was 34.5 percent. Chart 3 shows the percentage distribution of persons reimbursed for any type of service (HI and/or SMI) during 1967, by the amount reimbursed. Twenty-five percent of all persons reimbursed received less than \$50 each and accounted for only 1.6 percent of the total amount reimbursed under Medicare. At the other extreme, the 7.5 percent of persons reimbursed \$2,000 or more accounted for 39 percent of the total funds expended.

#### SUMMARY

The Medicare program has provided insurance against part of the cost of medical care for al-

CHART 3.—Persons served and amounts reimbursed under Medicare, by estimated amount reimbursed, 1967



most all persons aged 65 and over since July 1, 1966. The use of inhospital services (and all supporting medical services) rose with the introduction of the program and continued to increase but at a declining rate. The average length of each hospital stay has actually dropped slightly. The use of ambulatory physician services has remained fairly stable throughout the program. There has been very little use of the posthospital alternatives—extended-care facilities and home health services.

Annual per capita expenditures under Medicare have more than doubled since the program began owing mainly to increases in charges to the pro-

gram for covered services. A large proportion of the funds are spent on behalf of a relatively small number of persons with serious illnesses.

These expenditures reflect the uneven distribution of medical services among the population aged 65 and over. Annually, about 20 percent of the insured population uses no covered service. Another 20 percent is hospitalized each year; among these persons, one-fourth are hospitalized more than once in the year. The bulk of physician costs arise out of hospitalized illnesses. In 1967, reimbursements for total covered costs of illness of hospitalized persons accounted for 86 percent of the program funds.

APPENDIX C

NATIONAL AND STATE MEDICARE PROFILES

**BENEFICIARIES (as of 1/1/71 ) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7/1/71 )  
BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7/1/70 - 6/30/71 )**

**National**

BENEFICIARIES <sup>1</sup>	HEALTH CARE RESOURCES
<ul style="list-style-type: none"> <li>• Hospital Insurance-20, 407, 383</li> <li>• Medical Insurance-19, 707, 894</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals<sup>2</sup>- 6, 745 General-6, 315 ; PSYCH.-335 ; TB-95 General Beds-868, 322 Per 1,000 beneficiaries-42.5</li> <li>• Extended Care Facilities-4, 287 Beds<sup>3</sup>-307, 548 Per 1,000 beneficiaries-15.1</li> <li>• Home Health Agencies 2, 284</li> <li>• Independent Laboratories- 2, 751</li> </ul>
BENEFITS PAID	ADMISSIONS AND STARTS OF CARE <sup>4</sup>
<ul style="list-style-type: none"> <li>• Hospital Insurance-<sup>5</sup> 5, 442, 971, 000</li> <li>• Medical Insurance- 2, 034, 999, 000</li> </ul>	<ul style="list-style-type: none"> <li>• Inpatient Hospital Admissions- 6, 229, 387 Per 1,000 beneficiaries-305.2</li> <li>• Extended Care Facility Admissions-417, 384 Per 1,000 beneficiaries-20.4</li> <li>• Home Health Starts of Care<sup>5</sup> 244, 350 Per 1,000 beneficiaries-12.0</li> </ul>

1 Based on data recorded as of November 1, 1971.

2 Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on accreditation of Hospitals or the American Osteopathic Association.

3 Includes skilled nursing beds only.

4 Data reported reflect the actual date of admission (or start of care) notices received and processed by the Social Security Administration through January 1972. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision or additional notices of admission or start of care in fiscal year 1971 are received and processed by the Social Security Administration.

5 Includes home health start of care of notices from both hospital insurance and medical insurance.

BENEFICIARIES (as of 1-1-71 ) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71 )  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71 )

ALABAMA

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance-330, 882		• Hospitals-129	General-127	; PSYCH.-1 ; TB-1 General Beds-13, 860 Per 1,000 beneficiaries-41.9
• Medical Insurance-322, 281		• Extended Care Facilities-96	Beds-6, 297	Per 1,000 beneficiaries-19.0
		• Home Health Agencies	63	
		• Independent Laboratories	12	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance-70, 600, 000		• Inpatient	Hospital Admissions-111, 113	Per 1,000 beneficiaries-335.8
• Medical Insurance-26, 706, 000		• Extended Care	Facility Admissions-5, 407	Per 1,000 beneficiaries-16.3
		• Home Health Starts of Care-2, 721		Per 1,000 beneficiaries- 8.2

ALASKA

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance-6, 804		• Hospitals-20	General-19	; PSYCH.-1 ; TB-0 General Beds- 666 Per 1,000 beneficiaries-97.9
• Medical Insurance-5, 470		• Extended Care Facilities-6	Beds-186	Per 1,000 beneficiaries-27.3
		• Home Health Agencies-1		
		• Independent Laboratories-2		
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance-1, 526, 000		• Inpatient	Hospital Admissions-1, 847	Per 1,000 beneficiaries-271.5
• Medical Insurance-434, 000		• Extended Care	Facility Admissions-49	Per 1,000 beneficiaries-7.2
		• Home Health Starts of Care-2		Per 1,000 beneficiaries-.3

ARIZONA

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance- 160, 887		• Hospitals-60	General-55	; PSYCH.-3 ; TB-2 General Beds-6, 569 Per 1,000 beneficiaries-40.8
• Medical Insurance- 154, 859		• Extended Care Facilities	19 Beds-1, 435	Per 1,000 beneficiaries-8.9
		• Home Health Agencies-9		
		• Independent Laboratories-43		
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance-51, 515, 000		• Inpatient	Hospital Admissions- 53, 419	Per 1,000 beneficiaries-332.0
• Medical Insurance 18, 719, 000		• Extended Care	Facility Admissions-3, 585	Per 1,000 beneficiaries-22.3
		• Home Health Starts of Care-2, 162		Per 1,000 beneficiaries-13.4

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71);  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71)

ARKANSAS

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	-240, 649	• Hospitals--99 General--96 General Beds--8, 427	; PSYCH.--2 ; TB-1 Per 1,000 beneficiaries--35.0	
• Medical Insurance	-232, 805	• Extended Care Facilities--20 Beds--1, 014		Per 1,000 beneficiaries--4.3
BENEFITS PAID			ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance	-44, 866, 000	• Inpatient Hospital Admissions--94, 625		Per 1,000 beneficiaries--393.2
• Medical Insurance	-15, 105, 000	• Extended Care Facility Admissions--1, 262		Per 1,000 beneficiaries--5.2
		• Home Health Starts of Care--1, 551		Per 1,000 beneficiaries--0.4

CALIFORNIA

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	-1, 804, 929	• Hospitals--586 General--549 General Beds--75, 793	; PSYCH.--34 ; TB-3 Per 1,000 beneficiaries--42.0	
• Medical Insurance	-1, 765, 969	• Extended Care Facilities--954 Beds--79, 917		Per 1,000 beneficiaries--44.3
BENEFITS PAID			ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance	-585, 237, 000	• Inpatient Hospital Admissions--517, 476		Per 1,000 beneficiaries--266.7
• Medical Insurance	-279, 893, 000	• Extended Care Facility Admissions--90, 505		Per 1,000 beneficiaries--50.1
		• Home Health Starts of Care--23, 086		Per 1,000 beneficiaries--12.8

COLORADO

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	-191, 440	• Hospitals--88 General--84 General Beds--9, 920	; PSYCH.--4 ; TB-0 Per 1,000 beneficiaries--51.8	
• Medical Insurance	-187, 009	• Extended Care Facilities--72 Beds--4, 911		Per 1,000 beneficiaries--25.7
BENEFITS PAID			ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance	-54, 070, 000	• Inpatient Hospital Admissions--72, 153		Per 1,000 beneficiaries--376.9
• Medical Insurance	-23, 641, 000	• Extended Care Facility Admissions--4, 756		Per 1,000 beneficiaries--24.8
		• Home Health Starts of Care--2, 569		Per 1,000 beneficiaries--13.4

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71)

CONNECTICUT

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance- 291, 029		• Hospitals-51	General-43	; PSYCH.-8 ; TB-0 General Beds-10, 885 Per 1,000 beneficiaries-37.4
• Medical Insurance-285, 120		• Extended Care Facilities-112	Beds-9, 456	Per 1,000 beneficiaries- 32.5
ADMISSIONS AND STARTS OF CARE				
• Hospital Insurance- 86, 550, 000		• Inpatient Hospital Admissions-73, 389		Per 1,000 beneficiaries-252.2
• Medical Insurance- 26, 627, 000		• Extended Care Facility Admissions-9, 358		Per 1,000 beneficiaries- 32.2
		• Home Health Starts of Care-5, 526		Per 1,000 beneficiaries- 19.0

DELAWARE

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance-45, 700		• Hospitals-9	General-7	; PSYCH.-1 ; TB-1 General Beds-1, 673 Per 1,000 beneficiaries-36.6
• Medical Insurance-44, 259		• Extended Care Facilities-12	Beds-591	Per 1,000 beneficiaries-12.9
ADMISSIONS AND STARTS OF CARE				
• Hospital Insurance- 11, 906, 000		• Inpatient Hospital Admissions-10, 973		Per 1,000 beneficiaries-240.1
• Medical Insurance-3, 532, 000		• Extended Care Facility Admissions-979		Per 1,000 beneficiaries- 21.4
		• Home Health Starts of Care- 849		Per 1,000 beneficiaries- 18.6

DISTRICT OF COLUMBIA

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance- 65, 894		• Hospitals-15	General-13	; PSYCH.-2 ; TB-0 General Beds-5, 364 Per 1,000 beneficiaries-81.4
• Medical Insurance- 62, 137		• Extended Care Facilities 5	Beds-884	Per 1,000 beneficiaries- 13.4
ADMISSIONS AND STARTS OF CARE				
• Hospital Insurance- 29, 089, 000		• Inpatient Hospital Admissions-21, 075		Per 1,000 beneficiaries-319.8
• Medical Insurance 9, 861, 000		• Extended Care Facility Admissions-440		Per 1,000 beneficiaries- 6.7
		• Home Health Starts of Care-1, 550		Per 1,000 beneficiaries- 23.5

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71)

FLORIDA

BENEFICIARIES	HEALTH CARE RESOURCES		
• Hospital Insurance-938, 665	Hospitals--190	General-181	; PSYCH.--7 ; TB-2
• Medical Insurance-915, 946	General Beds-28, 750		Per 1,000 beneficiaries-30.6
BENEFITS PAID	ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance-240, 109, 000	Inpatient	Hospital Admissions-298, 462	Per 1,000 beneficiaries-318.0
• Medical Insurance-134, 204, 000	Extended Care	Facility Admissions-21, 443	Per 1,000 beneficiaries-22.8
	Home Health Agencies	42	Per 1,000 beneficiaries-8.8
	Independent Laboratories	117	

GEORGIA

BENEFICIARIES	HEALTH CARE RESOURCES		
• Hospital Insurance-370, 454	Hospitals- 163	General- 156	; PSYCH.-6 ; TB-1
• Medical Insurance-359, 183	General Beds-16, 902		Per 1,000 beneficiaries-45.6
BENEFITS PAID	ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance-69, 717, 000	Inpatient	Hospital Admissions-124, 850	Per 1,000 beneficiaries-337.0
• Medical Insurance-29, 752, 000	Extended Care	Facility Admissions-4, 387	Per 1,000 beneficiaries-11.8
	Home Health Agencies	19	Per 1,000 beneficiaries-6.9
	Independent Laboratories	21	

HAWAII

BENEFICIARIES	HEALTH CARE RESOURCES		
• Hospital Insurance-45, 776	Hospitals-25	General-24	; PSYCH.-1 ; TB-0
• Medical Insurance-44, 827	General Beds-2, 669		Per 1,000 beneficiaries-58.3
BENEFITS PAID	ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance-11, 312, 000	Inpatient	Hospital Admissions-13, 154	Per 1,000 beneficiaries-287.4
• Medical Insurance 5, 874, 000	Extended Care	Facility Admissions-1, 143	Per 1,000 beneficiaries-25.0
	Home Health Starts of Care-913		Per 1,000 beneficiaries-19.9

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71)

IDAHO

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance- 70, 405		• Hospitals-47 General-46 ; PSYCH.-0 ; TB-1 General Beds- 2, 535 Per 1,000 beneficiaries-36.0	
• Medical Insurance- 68, 167		• Extended Care Facilities-34 Beds- 1, 784 Per 1,000 beneficiaries-25.3	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance-13, 530, 000		• Inpatient Hospital Admissions- 22, 308 Per 1,000 beneficiaries-316.9	
• Medical Insurance--5, 723, 000		• Extended Care Facility Admissions- 1, 962 Per 1,000 beneficiaries-27.9	
		• Home Health Starts of Care-762 Per 1,000 beneficiaries--10.8	

ILLINOIS

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance-1, 102, 127		• Hospitals- 291 General- 264 ; PSYCH.- 18 ; TB- 9 General Beds- 56, 646 Per 1,000 beneficiaries- 51.4	
• Medical Insurance-1, 068, 420		• Extended Care Facilities- 154 Beds- 8, 622 Per 1,000 beneficiaries-7.8	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance-314, 575, 000		• Inpatient Hospital Admissions- 334, 149 Per 1,000 beneficiaries-303.2	
• Medical Insurance-90, 704, 000		• Extended Care Facility Admissions- 16, 069 Per 1,000 beneficiaries-14.6	
		• Home Health Starts of Care-7, 553 Per 1,000 beneficiaries-6.9	

INDIANA

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance- 499, 618		• Hospitals-134 General- 124 ; PSYCH.- 7 ; TB- 3 General Beds- 20, 215 Per 1,000 beneficiaries- 40.5	
• Medical Insurance- 481, 111		• Extended Care Facilities 94 Beds- 4, 100 Per 1,000 beneficiaries- 8.2	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance-113, 047, 000		• Inpatient Hospital Admissions- 141, 002 Per 1,000 beneficiaries-282.2	
• Medical Insurance 35, 450, 000		• Extended Care Facility Admissions- 8, 796 Per 1,000 beneficiaries-17.6	
		• Home Health Starts of Care- 3, 767 Per 1,000 beneficiaries-7.5	

**BENEFICIARIES (as of 1-1-71 ) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71 )  
BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71 )**

**IOWA**

<b>BENEFICIARIES</b>		<b>HEALTH CARE RESOURCES</b>		
• Hospital Insurance	-356,057	• Hospitals-149	General-143	; PSYCH.-5 ; TB-1 General Beds-14,793 Per 1,000 beneficiaries-41.5
• Medical Insurance	-347,353	• Extended Care Facilities-67	Beds-2,528	Per 1,000 beneficiaries-7.1
<b>BENEFITS PAID</b>			<b>ADMISSIONS AND STARTS OF CARE</b>	
• Hospital Insurance	-83,220,000	• Inpatient	Hospital Admissions-124,825	Per 1,000 beneficiaries-350.6
• Medical Insurance	-24,292,000	• Extended Care	Facility Admissions-5,232	Per 1,000 beneficiaries-14.7
		• Home Health Agencies	Home Health Starts of Care-1,558	Per 1,000 beneficiaries-4.4
		• Independent Laboratories	-14	

**KANSAS**

<b>BENEFICIARIES</b>		<b>HEALTH CARE RESOURCES</b>		
• Hospital Insurance	-269,934	• Hospitals-163	General-157	; PSYCH.-5 ; TB-1 General Beds-12,499 Per 1,000 beneficiaries-46.3
• Medical Insurance	-261,791	• Extended Care Facilities-40	Beds-798	Per 1,000 beneficiaries-3.0
<b>BENEFITS PAID</b>			<b>ADMISSIONS AND STARTS OF CARE</b>	
• Hospital Insurance	-61,104,000	• Inpatient	Hospital Admissions-97,979	Per 1,000 beneficiaries-363.0
• Medical Insurance	-19,976,000	• Extended Care	Facility Admissions-2,448	Per 1,000 beneficiaries-9.1
		• Home Health Agencies	Home Health Starts of Care-1,598	Per 1,000 beneficiaries-5.9
		• Independent Laboratories	-23	

**KENTUCKY**

<b>BENEFICIARIES</b>		<b>HEALTH CARE RESOURCES</b>		
• Hospital Insurance	-342,911	• Hospitals-128	General-116	; PSYCH.-5 ; TB-7 General Beds-12,197 Per 1,000 beneficiaries-35.6
• Medical Insurance	-335,109	• Extended Care Facilities	83 Beds-5,444	Per 1,000 beneficiaries-15.9
<b>BENEFITS PAID</b>			<b>ADMISSIONS AND STARTS OF CARE</b>	
• Hospital Insurance	-67,617,000	• Inpatient	Hospital Admissions-115,351	Per 1,000 beneficiaries-336.4
• Medical Insurance	-23,098,000	• Extended Care	Facility Admissions-8,048	Per 1,000 beneficiaries-23.5
		• Home Health Agencies	Home Health Starts of Care-2,910	Per 1,000 beneficiaries-8.5
		• Independent Laboratories	-30	

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71)

LOUISIANA

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	308,363	• Hospitals-130 General Beds-14,290	General-126 ; PSYCH.-3	; TB-1 Per 1,000 beneficiaries-46.3
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance	69,958,000	• Inpatient Hospital Admissions-108,843		Per 1,000 beneficiaries-353.0
• Medical Insurance	23,381,000	• Extended Care Facility Admissions-2,066		Per 1,000 beneficiaries-6.7
		• Home Health Agencies-80		Per 1,000 beneficiaries-19.6
		• Independent Laboratories-28		

MAINE

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	121,289	• Hospitals-58 General Beds-4,554	General-58 ; PSYCH.-0	; TB-0 Per 1,000 beneficiaries-37.5
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance	25,986,000	• Inpatient Hospital Admissions-37,162		Per 1,000 beneficiaries-306.4
• Medical Insurance	6,516,000	• Extended Care Facility Admissions-1,953		Per 1,000 beneficiaries-16.1
		• Home Health Starts of Care-1,898		Per 1,000 beneficiaries-15.6
		• Independent Laboratories-0		

MARYLAND

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	295,916	• Hospitals-61 General Beds-12,150	General-51 ; PSYCH.-8	; TB-2 Per 1,000 beneficiaries-41.1
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance	74,842,000	• Inpatient Hospital Admissions-66,993		Per 1,000 beneficiaries-226.4
• Medical Insurance	23,521,000	• Extended Care Facility Admissions-5,961		Per 1,000 beneficiaries-20.1
		• Home Health Starts of Care-3,106		Per 1,000 beneficiaries-10.5
		• Independent Laboratories-61		

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71)

MASSACHUSETTS

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	- 635,333	Hospitals- 186	General-165 ; PSYCH.-18 ; TB-3	Per 1,000 beneficiaries-48.4
• Medical Insurance	- 621,047	General Beds-30,719		
BENEFITS PAID			ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance	- 285,195,000	Inpatient Hospital Admissions-186,290	Per 1,000 beneficiaries-293.2	
• Medical Insurance	- 71,549,000	Extended Care Facility Admissions-13,216	Per 1,000 beneficiaries-20.8	
		Home Health Starts of Care-13,078	Per 1,000 beneficiaries-20.6	

MICHIGAN

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	- 774,784	Hospitals-254	General-238 ; PSYCH.-15 ; TB-1	Per 1,000 beneficiaries-46.9
• Medical Insurance	- 753,529	General Beds-36,363		
BENEFITS PAID			ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance	- 243,475,000	Extended Care Facility Admissions-151	Per 1,000 beneficiaries-17.9	
• Medical Insurance	- 78,245,000	Beds-13,891		
		Home Health Agencies-49		
		Independent Laboratories-94		

MINNESOTA

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	- 417,095	Hospitals-196	General-186 ; PSYCH.-7 ; TB-3	Per 1,000 beneficiaries-46.2
• Medical Insurance	- 408,385	General Beds-19,260		
BENEFITS PAID			ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance	- 124,348,000	Extended Care Facilities 102	Per 1,000 beneficiaries-10.8	
• Medical Insurance	- 39,362,000	Beds-4,515		
		Home Health Agencies-57		
		Independent Laboratories-12		

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71)

MISSISSIPPI

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance-227, 177		Hospitals- 107 General- 106 ; PSYCH.-0 ; TB-1 General Beds-8, 511 Per 1,000 beneficiaries-37.5	
• Medical Insurance- 216, 605		Extended Care Facilities-30 Beds-1, 418 Per 1,000 beneficiaries-6.2	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance-46, 301, 000		Inpatient Hospital Admissions-88, 883 Per 1,000 beneficiaries-391.2	
• Medical Insurance-22, 317, 000		Extended Care Facility Admissions-3, 428 Per 1,000 beneficiaries-15.1	
		Home Health Starts of Care-2, 003 Per 1,000 beneficiaries-8.8	

MISSOURI

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance-563, 659		Hospitals- 175 General- 165 ; PSYCH.-10 ; TB-0 General Beds-25, 015 Per 1,000 beneficiaries-44.4	
• Medical Insurance-546, 593		Extended Care Facilities-59 Beds-3, 639 Per 1,000 beneficiaries-6.5	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance-149, 527, 000		Inpatient Hospital Admissions-189, 994 Per 1,000 beneficiaries-337.1	
• Medical Insurance-45, 292, 000		Extended Care Facility Admissions-5, 091 Per 1,000 beneficiaries-9.0	
		Home Health Starts of Care-7, 669 Per 1,000 beneficiaries-13.6	

MONTANA

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance-70, 642		Hospitals- 63 General- 61 ; PSYCH.-1 ; TB-1 General Beds- 3, 523 Per 1,000 beneficiaries-49.9	
• Medical Insurance- 68, 616		Extended Care Facilities 20 Beds-578 Per 1,000 beneficiaries-8.2	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance-16, 710, 000		Inpatient Hospital Admissions-29, 799 Per 1,000 beneficiaries- 421.8	
• Medical Insurance 5, 257, 000		Extended Care Facility Admissions- 998 Per 1,000 beneficiaries-14.1	
		Home Health Starts of Care-341 Per 1,000 beneficiaries- 4.8	

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE ( 7-1-70 - 6-30-71 )

NEBRASKA

BENEFICIARIES	HEALTH CARE RESOURCES		
• Hospital Insurance-185, 138 • Medical Insurance-179, 714	• Hospitals-112 General- 107 ; PSYCH.- 4 ; TB- 1 General Beds- 8, 258 • Extended Care Facilities-23 Beds- 1, 064 • Home Health Agencies 5 • Independent Laboratories- 9		Per 1,000 beneficiaries- 44.6 Per 1,000 beneficiaries- 5.7
BENEFITS PAID	ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance-39, 363, 000 • Medical Insurance-15, 224, 000	• Inpatient Hospital Admissions-66, 776 • Extended Care Facility Admissions-2, 133 • Home Health Starts of Care- 861		Per 1,000 beneficiaries- 360.7 Per 1,000 beneficiaries- 11.5 Per 1,000 beneficiaries- 4.8

NEVADA

BENEFICIARIES	HEALTH CARE RESOURCES		
• Hospital Insurance- 32, 578 • Medical Insurance- 31, 277	• Hospitals-21 General-20 ; PSYCH.- 1 ; TB- 0 General Beds- 1, 840 • Extended Care Facilities- 16 Beds- 957 • Home Health Agencies- 3 • Independent Laboratories- 14		Per 1,000 beneficiaries- 56.5 Per 1,000 beneficiaries- 29.4
BENEFITS PAID	ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance- 11, 040, 000 • Medical Insurance- 3, 370, 000	• Inpatient Hospital Admissions-11, 014 • Extended Care Facility Admissions- 1, 372 • Home Health Starts of Care- 236		Per 1,000 beneficiaries- 338.1 Per 1,000 beneficiaries- 42.1 Per 1,000 beneficiaries- 7.2

NEW HAMPSHIRE

BENEFICIARIES	HEALTH CARE RESOURCES		
• Hospital Insurance- 83, 034 • Medical Insurance- 79, 921	• Hospitals-34 General-32 ; PSYCH.-2 ; TB- 0 General Beds- 2, 959 • Extended Care Facilities 13 Beds- 688 • Home Health Agencies- 41 • Independent Laboratories- 1		Per 1,000 beneficiaries- 35.6 Per 1,000 beneficiaries- 8.3
BENEFITS PAID	ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance- 18, 267, 000 • Medical Insurance 6, 317, 000	• Inpatient Hospital Admissions-24, 999 • Extended Care Facility Admissions-1, 768 • Home Health Starts of Care- 1, 949		Per 1,000 beneficiaries- 301.1 Per 1,000 beneficiaries- 21.3 Per 1,000 beneficiaries- 23.5

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71)

NEW JERSEY

BENEFICIARIES	HEALTH CARE RESOURCES		
BENEFITS PAID	ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance-700,363	• Hospitals- 117 General- 108 ; PSYCH.- 8 ; TB- 1 General Beds- 27,722	Per 1,000 beneficiaries- 39.6	
• Medical Insurance-684,215	• Extended Care Facilities- 104 Beds- 7,658	Per 1,000 beneficiaries- 10.9	
	• Home Health Agencies 49		
	• Independent Laboratories-128		
• Hospital Insurance-175,145,000	• Inpatient Hospital Admissions-163,397	Per 1,000 beneficiaries-233.3	
• Medical Insurance-82,235,000	• Extended Care Facility Admissions-16,845	Per 1,000 beneficiaries-24.1	
	• Home Health Starts of Care- 14,059	Per 1,000 beneficiaries-20.1	

NEW MEXICO

BENEFICIARIES	HEALTH CARE RESOURCES		
BENEFITS PAID	ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance-74,346	• Hospitals-44 General-43 ; PSYCH.-1 ; TB-0 General Beds-3,646	Per 1,000 beneficiaries- 49.0	
• Medical Insurance-70,513	• Extended Care Facilities- 16 Beds- 955	Per 1,000 beneficiaries- 12.8	
	• Home Health Agencies--5		
	• Independent Laboratories- 22		
• Hospital Insurance-14,902,000	• Inpatient Hospital Admissions- 23,103	Per 1,000 beneficiaries- 310.7	
• Medical Insurance- 6,153,000	• Extended Care Facility Admissions- 975	Per 1,000 beneficiaries- 13.1	
	• Home Health Starts of Care- 491	Per 1,000 beneficiaries- 6.6	

NEW YORK

BENEFICIARIES	HEALTH CARE RESOURCES		
BENEFITS PAID	ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance-1,975,605	• Hospitals- 394 General- 352 ; PSYCH.- 37 ; TB- 5 General Beds- 79,551	Per 1,000 beneficiaries-- 40.3	
• Medical Insurance-1,906,796	• Extended Care Facilities 292 Beds- 34,461	Per 1,000 beneficiaries- 17.4	
	• Home Health Agencies- 127		
	• Independent Laboratories- 233		
• Hospital Insurance- 630,156,000	• Inpatient Hospital Admissions- 479,962	Per 1,000 beneficiaries- 242.9	
• Medical Insurance 250,352,000	• Extended Care Facility Admissions-32,116	Per 1,000 beneficiaries- 16.3	
	• Home Health Starts of Care- 25,885	Per 1,000 beneficiaries- 13.1	

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE ( 7-1-70 - 6-30-71 )

NORTH CAROLINA

BENEFICIARIES	HEALTH CARE RESOURCES		
• Hospital Insurance- 423, 734	Hospitals- 147	General- 138 ; PSYCH.-5 ; TB- 4	General Beds-20, 648 Per 1,000 beneficiaries-48.7
• Medical Insurance- 409, 115	Extended Care Facilities- 52		Beds-4, 263 Per 1,000 beneficiaries-10.1
BENEFITS PAID			ADMISSIONS AND STARTS OF CARE
• Hospital Insurance-85, 051, 000	Inpatient	Hospital Admissions-132, 759	Per 1,000 beneficiaries-313.3
• Medical Insurance-29, 167, 000	Extended Care	Facility Admissions-6, 117	Per 1,000 beneficiaries-14.4
	Home Health Agencies	29	Per 1,000 beneficiaries-5.5
	Independent Laboratories	14	

NORTH DAKOTA

BENEFICIARIES	HEALTH CARE RESOURCES		
• Hospital Insurance- 68, 511	Hospitals- 60	General-59 ; PSYCH.-1 ; TB-	General Beds-3, 449 Per 1,000 beneficiaries-50.3
• Medical Insurance-66, 634	Extended Care Facilities-5		Beds-307 Per 1,000 beneficiaries-4.5
	Home Health Agencies- 9		
	Independent Laboratories- 9		
BENEFITS PAID			ADMISSIONS AND STARTS OF CARE
• Hospital Insurance-19, 910, 000	Inpatient	Hospital Admissions-31, 563	Per 1,000 beneficiaries- 460.7
• Medical Insurance-5, 660, 000	Extended Care	Facility Admissions-403	Per 1,000 beneficiaries-5.9
	Home Health Starts of Care-237		Per 1,000 beneficiaries-3.5

OHIO

BENEFICIARIES	HEALTH CARE RESOURCES		
• Hospital Insurance-1, 004, 051	Hospitals- 249	General-223 ; PSYCH.-14 ; TB-12	General Beds-44, 265 Per 1,000 beneficiaries- 44.1
• Medical Insurance-969, 113	Extended Care Facilities	193	Beds-15, 531 Per 1,000 beneficiaries- 15.5
	Home Health Agencies- 96		
	Independent Laboratories- 99		
BENEFITS PAID			ADMISSIONS AND STARTS OF CARE
• Hospital Insurance-268, 906, 000	Inpatient	Hospital Admissions-280, 400	Per 1,000 beneficiaries-279.3
• Medical Insurance 73, 708, 000	Extended Care	Facility Admissions-23, 937	Per 1,000 beneficiaries-23.8
	Home Health Starts of Care-13, 755		Per 1,000 beneficiaries- 13.7

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71)

OKLAHOMA

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance	299,458	• Hospitals-135 General-130 ; PSYCH.-4 ; TB-1 General Beds-11,331 Per 1,000 beneficiaries-37.8	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance	66,359,000	• Inpatient Hospital Admissions-113,680 Per 1,000 beneficiaries-379.6	
• Medical Insurance	28,917,000	• Extended Care Facility Admissions-3,110 Per 1,000 beneficiaries-10.4 • Home Health Starts of Care-2,081 Per 1,000 beneficiaries-6.9	

OREGON

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance	230,029	• Hospitals-89 General-85 ; PSYCH.-3 ; TB-1 General Beds-7,342 Per 1,000 beneficiaries-31.9	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance	53,934,000	• Inpatient Hospital Admissions-67,218 Per 1,000 beneficiaries-292.2	
• Medical Insurance	21,712,000	• Extended Care Facility Admissions-7,639 Per 1,000 beneficiaries-33.2 • Home Health Starts of Care-3,400 Per 1,000 beneficiaries-14.8	

PENNSYLVANIA

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance	1,283,947	• Hospitals-288 General-256 ; PSYCH.-29 ; TB-3 General Beds-51,452 Per 1,000 beneficiaries-40.1	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance	318,284,000	• Inpatient Hospital Admissions-345,572 Per 1,000 beneficiaries-269.1	
• Medical Insurance	120,727,000	• Extended Care Facility Admissions-22,302 Per 1,000 beneficiaries-17.4 • Home Health Starts of Care-25,439 Per 1,000 beneficiaries-19.8	

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71)

RHODE ISLAND

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance-105, 231		• Hospitals-20 General-17 ; PSYCH.-3 ; TB-0 General Beds- 4, 525 Per 1,000 beneficiaries- 43.0	
• Medical Insurance-102, 486		• Extended Care Facilities- 24 Beds- 1, 301 Per 1,000 beneficiaries- 12.4	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance-31, 820, 000		• Inpatient Hospital Admissions-26, 852 Per 1,000 beneficiaries- 255.2	
• Medical Insurance-11, 678, 000		• Extended Care Facility Admissions-3, 713 Per 1,000 beneficiaries- 35.3	
		• Home Health Starts of Care- 3, 202 Per 1,000 beneficiaries- 30.4	

SOUTH CAROLINA

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance-196, 604		• Hospitals- 76 General-71 ; PSYCH.-4 ; TB-1 General Beds- 8, 839 Per 1,000 beneficiaries- 45.0	
• Medical Insurance-187, 171		• Extended Care Facilities- 60 Beds- 4, 174 Per 1,000 beneficiaries- 21.2	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance-32, 480, 000		• Inpatient Hospital Admissions-59, 110 Per 1,000 beneficiaries- 300.7	
• Medical Insurance-12, 406, 000		• Extended Care Facility Admissions- 3, 683 Per 1,000 beneficiaries- 18.7	
		• Home Health Starts of Care- 2, 924 Per 1,000 beneficiaries- 14.9	

SOUTH DAKOTA

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance-81, 938		• Hospitals- 65 General-65 ; PSYCH.- ; TB-0 General Beds- 3, 760 Per 1,000 beneficiaries- 45.9	
• Medical Insurance- 79, 441		• Extended Care Facilities 11 Beds- 511 Per 1,000 beneficiaries- 6.2	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance-18, 473, 000		• Inpatient Hospital Admissions-32, 313 Per 1,000 beneficiaries- 394.4	
• Medical Insurance 5, 087, 000		• Extended Care Facility Admissions- 808 Per 1,000 beneficiaries- 9.9	
		• Home Health Starts of Care-750 Per 1,000 beneficiaries- 9.2	

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71)

TENNESSEE

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance- 391,573		• Hospitals- 143 General--135 ; PSYCH.-4 ; TB-4 General Beds-17, 412 Per 1,000 beneficiaries- 44.5	
• Medical Insurance- 380,479		• Extended Care Facilities- 60 Beds-2, 917	Per 1,000 beneficiaries- 7.4
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance-93, 147, 000		• Inpatient Hospital Admissions- 140, 222	Per 1,000 beneficiaries- 358.1
• Medical Insurance-28, 210, 000		• Extended Care Facility Admissions-6, 709	Per 1,000 beneficiaries- 17.1
		• Home Health Agencies- 83	Per 1,000 beneficiaries- 7.0
		• Independent Laboratories- 23	

TEXAS

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance-1, 001, 909		• Hospitals- 493 General- 481 ; PSYCH.-9 ; TB-3 General Beds-46, 084	Per 1,000 beneficiaries- 46.0
• Medical Insurance-980, 835		• Extended Care Facilities- 130 Beds- 6, 974	Per 1,000 beneficiaries- 7.0
		• Home Health Agencies- 64	
		• Independent Laboratories- 150	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance-256, 370, 000		• Inpatient Hospital Admissions-386, 903	Per 1,000 beneficiaries- 386.2
• Medical Insurance-110, 884, 000		• Extended Care Facility Admissions- 12, 404	Per 1,000 beneficiaries- 12.4
		• Home Health Starts of Care- 9, 009	Per 1,000 beneficiaries- 9.0

UTAH

BENEFICIARIES		HEALTH CARE RESOURCES	
• Hospital Insurance- 78, 740		• Hospitals- 38 General-37 ; PSYCH.-1 ; TB-0 General Beds- 3, 466	Per 1,000 beneficiaries- 44.0
• Medical Insurance- 75, 389		• Extended Care Facilities 21 Beds- 950	Per 1,000 beneficiaries- 12.1
		• Home Health Agencies- 12	
		• Independent Laboratories- 12	
BENEFITS PAID		ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance- 15, 139, 000		• Inpatient Hospital Admissions- 21, 959	Per 1,000 beneficiaries- 278.9
• Medical Insurance 6, 427, 000		• Extended Care Facility Admissions- 1, 403	Per 1,000 beneficiaries- 17.8
		• Home Health Starts of Care- 820	Per 1,000 beneficiaries- 10.4

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE ( 7-1-70 - 6-30-71 )

VERMONT

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	- 50,085	• Hospitals-21	General-19	; PSYCH.-2 ; TB-0 General Beds-1,941 Per 1,000 beneficiaries- 38.8
• Medical Insurance	- 48,944	• Extended Care Facilities- 13	Beds- 744	Per 1,000 beneficiaries- 14.9
ADMISSIONS AND STARTS OF CARE				
• Hospital Insurance	- 14,128,000	• Inpatient Hospital Admissions	- 16,789	Per 1,000 beneficiaries- 335.2
• Medical Insurance	- 4,153,000	• Extended Care Facility Admissions	- 1,232	Per 1,000 beneficiaries- 24.6
		• Home Health Starts of Care	- 1,556	Per 1,000 beneficiaries- 31.1

VIRGINIA

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	- 369,652	• Hospitals-117	General-105	; PSYCH.-9 ; TB-3 General Beds- 16,994 Per 1,000 beneficiaries- 46.0
• Medical Insurance	- 353,447	• Extended Care Facilities- 57	Beds- 3,572	Per 1,000 beneficiaries- 9.7
		• Home Health Agencies-136		
		• Independent Laboratories- 24		
ADMISSIONS AND STARTS OF CARE				
• Hospital Insurance	- 73,241,000	• Inpatient Hospital Admissions	- 110,130	Per 1,000 beneficiaries- 297.9
• Medical Insurance	- 29,235,000	• Extended Care Facility Admissions	- 5,174	Per 1,000 beneficiaries- 14.0
		• Home Health Starts of Care	- 2,192	Per 1,000 beneficiaries- 5.9

WASHINGTON

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	- 327,066	• Hospitals-118	General-110	; PSYCH.-6 ; TB-2 General Beds- 10,475 Per 1,000 beneficiaries- 32.0
• Medical Insurance	- 318,525	• Extended Care Facilities	106 Beds- 3,872	Per 1,000 beneficiaries- 11.8
		• Home Health Agencies- 23		
		• Independent Laboratories- 62		
ADMISSIONS AND STARTS OF CARE				
• Hospital Insurance	- 75,358,000	• Inpatient Hospital Admissions	- 102,259	Per 1,000 beneficiaries- 312.7
• Medical Insurance	- 30,434,000	• Extended Care Facility Admissions	- 11,757	Per 1,000 beneficiaries- 35.9
		• Home Health Starts of Care	- 3,871	Per 1,000 beneficiaries- 11.8

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)  
 BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71)

WEST VIRGINIA

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	-200, 260	• Hospitals- 80 General- 76	; PSYCH.-4	; TB-0
		General Beds- 8, 553	Per 1,000 beneficiaries- 42.7	
BENEFITS PAID			ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance	-39, 388, 000	• Inpatient Hospital Admissions- 72, 481	Per 1,000 beneficiaries- 361.9	
• Medical Insurance	-15, 592, 000	• Extended Care Facility Admissions- 2, 117	Per 1,000 beneficiaries- 10.6	
		• Home Health Starts of Care- 2, 289	Per 1,000 beneficiaries- 11.4	

WISCONSIN

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	-481, 224	• Hospitals- 176 General- 161	; PSYCH.-9	; TB-6
		General Beds- 20, 724	Per 1,000 beneficiaries - 43.1	
• Medical Insurance	-470, 705	• Extended Care Facilities- 134	Per 1,000 beneficiaries-- 16.3	
		Beds- 7, 833		
BENEFITS PAID			ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance	-123, 004, 000	• Inpatient Hospital Admissions- 152, 785	Per 1,000 beneficiaries- 317.5	
• Medical Insurance	-37, 293, 000	• Extended Care Facility Admissions- 7, 632	Per 1,000 beneficiaries- 15.9	
		• Home Health Starts of Care- 4, 824	Per 1,000 beneficiaries- 10.0	

WYOMING

BENEFICIARIES		HEALTH CARE RESOURCES		
• Hospital Insurance	-31, 357	• Hospitals- 29 General- 28	; PSYCH.- 1	; TB-
		General Beds- 1, 511	Per 1,000 beneficiaries- 48.2	
• Medical Insurance	-30, 196	• Extended Care Facilities 1	Per 1,000 beneficiaries-. 7	
		Beds- 23		
BENEFITS PAID			ADMISSIONS AND STARTS OF CARE	
• Hospital Insurance	-6, 422, 000	• Inpatient Hospital Admissions- 11, 616	Per 1,000 beneficiaries- 370.4	
• Medical Insurance	-1, 996, 000	• Extended Care Facility Admissions- 161	Per 1,000 beneficiaries- 5.1	
		• Home Health Starts of Care-- 194	Per 1,000 beneficiaries- 6.2	

BENEFICIARIES (as of 1-1-71) AND PARTICIPATING HEALTH CARE RESOURCES (as of 7-1-71)

BENEFITS PAID, ADMISSIONS AND HOME HEALTH STARTS OF CARE (7-1-70 - 6-30-71)

PUERTO RICO

BENEFICIARIES	HEALTH CARE RESOURCES		
• Hospital Insurance-177,508	Hospitals-97	General-92	; PSYCH.-2 ; TB-3
• Medical Insurance-94,975	General Beds-6,248		Per 1,000 beneficiaries- 35.2
	• Extended Care Facilities-9		
	Beds-517		Per 1,000 beneficiaries- 2.9
	• Home Health Agencies 3		
	• Independent Laboratories-65		
BENEFITS PAID	ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance-16,525,000	Inpatient Hospital Admissions-41,983		Per 1,000 beneficiaries- 236.5
• Medical Insurance-7,855,000	• Extended Care Facility Admissions-758		Per 1,000 beneficiaries- 4.3
	• Home Health Starts of Care- 1,527		Per 1,000 beneficiaries- 8.6

GUAM, VIRGIN ISLANDS, AND OTHER OUTLYING AREAS

BENEFICIARIES	HEALTH CARE RESOURCES		
• Hospital Insurance-5,023	Hospitals-5	General-5	; PSYCH.-0 ; TB-0
• Medical Insurance-4,036	General Beds-579		Per 1,000 beneficiaries- 115.3
	• Extended Care Facilities--1		
	Beds- 33		Per 1,000 beneficiaries- 6.6
	• Home Health Agencies-2		
	• Independent Laboratories-0		
BENEFITS PAID	ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance-432,000	Inpatient Hospital Admissions-1,013		Per 1,000 beneficiaries- 201.7
• Medical Insurance-76,000	• Extended Care Facility Admissions-20		Per 1,000 beneficiaries- 4.0
	• Home Health Starts of Care- 18		Per 1,000 beneficiaries- 3.6

BENEFICIARIES	HEALTH CARE RESOURCES		
• Hospital Insurance-	Hospitals-	General-	; PSYCH.- ; TB-
• Medical Insurance-	General Beds-		Per 1,000 beneficiaries-
	• Extended Care Facilities		
	Beds-		Per 1,000 beneficiaries--
	• Home Health Agencies-		
	• Independent Laboratories-		
BENEFITS PAID	ADMISSIONS AND STARTS OF CARE		
• Hospital Insurance--	Inpatient Hospital Admissions-		Per 1,000 beneficiaries--
• Medical Insurance	• Extended Care Facility Admissions-		Per 1,000 beneficiaries--
	• Home Health Starts of Care--		Per 1,000 beneficiaries--

APPENDIX D

## ADMINISTRATIVE STRUCTURE OF THE MEDICARE PROGRAM

Overall responsibility for administration of Medicare is vested by law in the Secretary of Health, Education, and Welfare. The statute also provides for significant participation in certain areas of administration by private organizations and public agencies, as well as for the establishment of a Health Insurance Benefits Advisory Council (HIBAC) to advise the Secretary on general policy in administering the Medicare program and in the formulation of regulations.

Within the Department of Health, Education, and Welfare, primary responsibility for administering the Medicare program is assigned to the Social Security Administration. Special responsibilities in connection with the health care standards of Medicare have been assigned to the Public Health Service, and certain responsibilities regarding relations between Medicare and State medical assistance programs are coordinated by the Social Security Administration and the Social and Rehabilitation Service. Responsibility for assuring compliance by participating health care facilities with title VI of the Civil Rights Act of 1964 is assigned to the Office of Civil Rights of the Department.

### Role of the Social Security Administration

The Social Security Administration negotiates and administers agreements with the intermediaries and carriers which perform payment and other program functions; with the State agencies which certify health facilities for participation in the program; and with hospitals and other institutions which provide services for which the program makes reimbursement; develops reimbursement principles and guidelines; works with the Public Health Service in the formulation and periodic review of the conditions of participation; formulates Medicare regulations; develops program policy and procedural instructions; and performs the basic recordkeeping and data processing functions required for administration of the program. Within the Administration, the Bureau of Health Insurance has been assigned primary responsibility for the formulation of policies and procedures and for the overall administration of the health insurance program.

In addition to the Bureau of Health Insurance, many other Administration components have substantial program responsibilities. The Administration's field organization--including approximately

district and branch offices, and more than 3,000 contact stations throughout the country--carries out enrollment activities and serves as a readily accessible source of program information and direct service to beneficiaries, the professional community, and the general public. In addition, district offices perform certain claims development and investigative activities for Medicare carriers and intermediaries.

The Office of Research and Statistics collects data on program operations and carries out analytical studies designed to evaluate the program and measure its performance.

The Office of the Actuary has responsibility for the actuarial evaluation of the hospital insurance and medical insurance programs, including the preparation of the actuarial estimates used in setting the medical insurance premium and hospital insurance deductible and coinsurance amounts.

The Office of Public Affairs which has primary responsibility for developing and coordinating the Administration's information activities, works with the Bureau of Health Insurance in the preparation of exhibits, films, visual aids, booklets, and other materials needed to inform the general public, as well as special professional audiences, about program benefits and requirements and claims procedures.

The Bureau of Data Processing, through its electronic data processing capabilities, maintains the millions of records on beneficiary eligibility, utilization of covered services, and deductible status. The Bureau also sends premium notices to, and maintains records on the payment of medical insurance premiums by the approximately 3.25 million enrollees who make direct payments or for whom premium payment is made through State agency "buy-in" arrangements or through private retirement groups.

An insurance compliance staff in the Office of Administration assures that the intermediaries and carriers assisting in the administration of Medicare fully comply with equal employment opportunity requirements.

#### Role of the Health Services and Mental Health Administration

The Health Services and Mental Health Administration (both at its headquarters and in its regional offices) acts as a primary resource regarding professional health aspects of the Medicare program, participating with the Social Security Administration in formulating and revising the conditions of participation for providers of services, developing policies on the role of State agencies, providing assistance to the State agencies in carrying out their Medicare responsibilities, supporting and evaluating experimental approaches to utilization

review, and providing professional advice in many technical and medical areas of program administration.

#### Role of the Social and Rehabilitation Service

The Social and Rehabilitation Service collaborates with the Social Security Administration and the Public Health Service in those aspects of program planning, coordination, and evaluation involving the interrelationships of the health insurance program with State public assistance and medical assistance programs. In addition, the Social and Rehabilitation Service provides consultation and general and technical assistance to State agencies administering medical assistance programs to assure effective coordination between Medicare and the programs at the State level.

#### Role of the Office of Civil Rights

Title VI of the Civil Rights Act of 1964 provides that no institution, agency or activity receiving Federal financial assistance may engage in discriminatory practice on the basis of race, color or national origin. Thus before any hospital, extended care facility or home health agency may become a provider under Medicare, its compliance with the provisions of title VI must be assured. The Department's Office of Civil Rights determines whether Medicare providers meet this requirement and investigates complaints of discrimination.

#### Role of the State Agencies *y*

The law requires that, wherever possible, the Secretary use the services of appropriate State or local health agencies or other appropriate State or local agencies in determining whether providers of services and independent laboratories meet the conditions for participation in the Medicare program. All 55 jurisdictions (including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa) have designated agencies--in most instances State health agencies--to perform this function.

In carrying out their Medicare responsibilities, State agencies conduct field surveys of institutions and agencies to determine the extent to which they meet the conditions of participation, undertake periodic resurveys of participating facilities to determine whether they continue to meet such conditions, provide consultative services to facilities experiencing difficulties in meeting the participation requirements, identify nonparticipating hospitals which can be reimbursed under the program for emergency services and coordinate activities under the health insurance program with activities under medical assistance programs. The State agencies are reimbursed for the costs of activities they perform in the program including related costs of administrative overhead and staff.

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*y* A list of State agencies having agreements with the Secretary of Health, Education, and Welfare under the Medicare program follows in this Appendix as Exhibit 1.

### Role of the Intermediaries 2/

Participating hospitals, extended care facilities, and home health agencies may receive reimbursement either through a fiscal intermediary, or if they prefer, directly from the Government. Virtually all providers have chosen to use intermediaries. Under agreements with the Secretary, intermediaries are responsible for determining the reasonable costs of services provided beneficiaries and for reimbursing providers on behalf of the program. In addition, the agreements authorize intermediaries to provide consultative services to providers, audit provider records, and perform related functions. All agreements also require that intermediaries assist providers in establishing and applying safeguards against unnecessary use of services covered by the program. As of June 30, 1971, the Blue Cross Association (with subcontracts to 73 Blue Cross Plans), 5 commercial health insurers, and 4 independent insurers were operating as fiscal intermediaries on behalf of over 13,200 participating providers and 2,900 independent laboratories. Further, 213 hospitals, 86 extended care facilities and 391 home health agencies, and 6 rehabilitation agencies were submitting bills directly to SSA.

### Role of the Carriers 2/

The Secretary is authorized by law to contract, to the extent possible, with nongovernmental organizations to serve as carriers for the medical insurance program. To qualify for consideration as a Medicare carrier such an organization must be engaged in providing, paying for, or reimbursing the cost of health services under group insurance policies or similar group arrangements, in return for premiums or other periodic charges. As of June 30, 1970, there were 33 Blue Shield plans, 13 insurance companies, 1 independent health insurer and 1 State agency operating as carriers.

Carriers determine the amounts to be paid to physicians and suppliers for services to Medicare beneficiaries and make payments for such services. Under their contracts carriers also are required to assist in the application of safeguards against the unnecessary utilization of services, and to serve as a channel of communication for information relating to the administration of the program.

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2/ A list of intermediaries and carriers operating under agreements with the Secretary of Health, Education, and Welfare follows in this Appendix as Exhibit 2.

Activities of the Health Insurance Benefits Advisory Council  
and Other Consultative Groups

Since enactment of the law in 1965, Medicare has drawn on the advice and consultation of experts representing every public and professional interest that would be affected by the program. In addition, we have had continuing contacts with individuals at all levels in the health field, the insurance industry and from the general public, either to solicit their expert advice or opinions, or in response to ideas and recommendations for program improvement which they submitted.

Of the various consultative groups, the Health Insurance Benefits Advisory Council, which was established by the original Medicare law, has had by far the most important consultative role on Medicare policies and procedures. In its advisory capacity, the Council has advised the Secretary with respect to every major policy and procedure affecting program implementation.

Originally the Council consisted of 16 members, private citizens representing the health care field and the general public. The Social Security Amendments of 1967 contained provisions which affected not only the size but also the functions of HIBAC. The most important was the transfer of all functions of the National Medical Review Committee (which had not been appointed) to HIBAC. To meet these increased responsibilities the size of the Council was increased from 16 to 19.<sup>3/</sup> Thus, in addition to its other responsibilities, the Council assumed responsibility for carrying out the statutory mandate "to study the utilization of hospital and other medical care and services for which payment may be made under this title." In addition, the 1967 amendments require HIBAC to submit an annual report to the Secretary of HEW for transmittal to Congress, and to engage such technical assistance as required to carry out its functions.

To meet its new responsibilities, the Council established an Ad Hoc Committee on the Evaluation of the Delivery and Use of Services (CEDUS). To support that Committee, the Council created task forces in the following areas: research and statistics; hospital and extended care services; home health services; medical services; and laboratory services. Each task force has been reinforced by expert consultants representing organized medicine, institutional providers, the insurance field, and consumer organizations.

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<sup>3/</sup> Section 1867(b)(2) of the Social Security Act, as amended.

STATE AGENCIES ADMINISTERING PROVIDER CERTIFICATION

ALABAMA: State Department of Public Health, Montgomery, Alabama

ALASKA: Alaska Department of Health and Welfare, Juneau, Alaska

ARIZONA: State Department of Health, Phoenix, Arizona

ARKANSAS: State Department of Health, Little Rock, Arkansas

CALIFORNIA: State Department of Public Health, Sacramento, California

COLORADO: Department of Public Health, Denver, Colorado

CONNECTICUT: State Department of Health, Hartford, Connecticut

DELAWARE: State Board of Health, Dover, Delaware

DISTRICT OF COLUMBIA: District of Columbia Department of Public Health,  
Washington, D.C.

FLORIDA: State Board of Health, Jacksonville, Florida

GEORGIA: Georgia Department of Public Health, Atlanta, Georgia

GUAM: Department of Public Health and Social Services, Agana, Guam

HAWAII: Hawaii Department of Health, Honolulu, Hawaii

IDAHO: Idaho Department of Health, Boise, Idaho

ILLINOIS: Illinois Department of Public Health, Springfield, Illinois

INDIANA: State Board of Health, Indianapolis, Indiana

IOWA: State Department of Health, Des Moines, Iowa

KANSAS: State Board of Health, Topeka, Kansas

KENTUCKY: Commonwealth of Kentucky State Department of Health, Frankfort,  
Kentucky

LOUISIANA: Louisiana Department of Hospitals, Baton Rouge, Louisiana

MAINE: Maine Department of Health and Welfare, Augusta, Maine

MARYLAND: State Department of Health, Baltimore, Maryland

MASSACHUSETTS: Massachusetts Department of Public Health, Boston, Mass.

MICHIGAN: Michigan Department of Health, Lansing, Michigan

MINNESOTA: State Department of Health, Minneapolis, Minnesota

MISSISSIPPI: Mississippi State Board of Health, Jackson, Mississippi

MISSOURI: State Division of Health, Jefferson City, Missouri

MONTANA: State Department of Health, Helena, Montana

NEBRASKA: State Department of Health, Lincoln, Nebraska

NEVADA: Department of Health, Welfare and Rehabilitation, Carson City, Nevada

NEW HAMPSHIRE: New Hampshire Division of Public Health, Concord, N.H.

NEW JERSEY: State Department of Health, Trenton, New Jersey

NEW MEXICO: New Mexico Health and Social Services, Santa Fe, New Mexico

NEW YORK: New York State Department of Health, Albany, New York

NORTH CAROLINA: State Board of Health, Raleigh, North Carolina

NORTH DAKOTA: State Department of Health, Bismark, North Dakota

OHIO: Ohio Department of Health, Columbus, Ohio

OKLAHOMA: State Department of Health, Oklahoma City, Oklahoma

OREGON: State Board of Health, Portland, Oregon

PENNSYLVANIA: Department of Health, Harrisburg, Pennsylvania

PUERTO RICO: Puerto Rico Department of Health, San Juan, Puerto Rico

RHODE ISLAND: Rhode Island Department of Health, Providence, Rhode Island

SOUTH CAROLINA: State Board of Health, Columbia, South Carolina

SOUTH DAKOTA: State Department of Health, Pierre, South Dakota

TENNESSEE: Tennessee Department of Public Health, Nashville, Tennessee

TEXAS: State Department of Health, Austin, Texas

UTAH: State Department of Health, Salt Lake City, Utah

VERMONT: Vermont Department of Health, Burlington, Vermont

VIRGIN ISLANDS: Virgin Islands Department of Health, St. Thomas, V.I.

VIRGINIA: State Department of Health, Richmond, Virginia

WASHINGTON: State Department of Health, Olympia, Washington

WEST VIRGINIA: State Health Department, Charleston, West Virginia

WISCONSIN: State Board of Health, Madison, Wisconsin

WYOMING: State Department of public Health, Cheyenne, Wyoming

Summary of Changes in Medicare Intermediaries and Carriers  
Between May 19, 1971 and April 14, 1972

Change in Carrier

The contract with Medical Mutual of Cleveland was not renewed and as of July 1, 1971, Nationwide Mutual Insurance Company was given responsibility for processing all Part B claims in Ohio.

Changes in Geographic Area

Since May 19, 1971, there have been three major changes in the geographic areas covered by intermediaries and carriers. These changes are shown below:

1. Part B work in four counties in Illinois was transferred from Illinois Medical Service to the Continental Casualty Company;
2. In the Virgin Islands, Part A work was shifted from Omaha Mutual to Cooperativa de Seguros de Vida de Puerto Rico and Part B work was moved from Omaha Mutual to Seguros de Servicio de Salud de Puerto Rico, Inc., and
3. In American Samoa, Part B responsibility was shifted from Aetna Insurance Company to Hawaii Medical Services.



District of ColumbiaIllinois

Group Hospitalization, Inc.  
550 12th Street, S.W.  
Washington, D.C. 20024

Mutual of Omaha Insurance Company 3

Florida

\*Medicare  
Blue Cross of Florida, Inc.  
P.O. Box 2711  
Jacksonville, Florida 32201

Aetna Life and Casualty y

The Travelers Insurance Company 2

Mutual of Omaha Insurance Company 3

Georgia

United Hospitals Service Association  
1612 Peachtree Street, N.W.  
Atlanta, Georgia 30309

Georgia Hospital Service Association,  
Inc.  
2137 Warm Springs Road  
Columbus, Georgia 31902

The Travelers Insurance Company 2

Hawaii

Hawaiian Medical Service Association  
P.O. Box 860  
Honolulu, Hawaii 96808

Kidder Foundation Health Plan, Inc. y

Idaho

Idaho Hospital Service Inc.  
1521 Federal Way  
Boise, Idaho 83707

Mutual of Omaha Insurance Company 3

Illinois

County of  
Cook

Hospital Service Corporation  
222 N. Dearborn Street  
Chicago, Illinois 60601

Illinois Hospital and Health  
Service, Inc.  
227 North Human Street  
Rockford, Illinois 61101

Aetna Life and Casualty y

Mutual of Omaha Insurance Company 3

Indiana

\*Mutual Hospital Insurance, Inc.  
110 North Illinois Street  
Indianapolis, Indiana 46204

Medicare  
Aetna Life and Casualty y

Iowa

Mutual Hospital Service, Inc. of Iowa  
Liberty Building  
Des Moines, Iowa 50307

\*Associated Hospitals Service, Inc.  
1622 Pierce Street  
Sioux City, Iowa 51102

Aetna Life and Casualty y

Mutual of Omaha Insurance Company 3

Kansas

Kansas Hospital Service Association,  
Inc.  
1133 Topeka Avenue  
Topeka, Kansas 66601

Medicare  
Surgical Care Inc.  
P.O. Box 169  
Kansas City, Missouri 64141

Kansas

Counties of:  
Wyandotte  
Johnson

Medicare  
Continental Casualty Co.  
P.O. Box 910  
Chicago, Illinois 60690

Illinois

Illinois Medical Service  
222 N. Dearborn  
Chicago, Illinois 60601

Illinois

Rest of State:

Illinois

Medicare

Continental Casualty Co.

P.O. Box 910

Chicago, Illinois 60690

Kansas (continued)

Maryland (continued)

Blue Cross of Kansas City  
3627 Broadway  
P.O. Box 165  
Kansas City, Missouri 64111.  
Aetna Life and Casualty J  
Mutual of Omaha Insurance Company J

Rest of State:

Medicare

Kansas Physicians' Service  
P.O. Box 923  
Topeka, Kansas 66601

Kentucky

Blue Cross Hospital Plan, Inc.  
301 Parktown Blvd.  
Louisville, Kentucky 40205  
Aetna Life and Casualty J

Mutual of Omaha Insurance Company J

Louisiana

Louisiana Hospital Service, Inc.  
1025 Florida Blvd.  
P.O. Box 136  
Baton Rouge, Louisiana 70315  
Hospital Service Association of  
New Orleans  
2025 St. Charles Avenue  
New Orleans, Louisiana 70130

Aetna Life and Casualty J

Louisiana

Medicare  
Par-American Life Insurance Co.  
P.O. Box 60450  
New Orleans, Louisiana 70160

Hospital Service Association of  
New Orleans  
2025 St. Charles Avenue  
New Orleans, Louisiana 70130

Aetna Life and Casualty J

Maine

Associated Hospital Service of Maine  
307 Forest Avenue  
Portland, Maine 04101  
The Travelers Insurance Company J

Maryland

\*Maryland Blue Cross, Inc.  
700 E. Joppa Road  
Towson, Maryland 21204

Counties of:

Montgomery

Prince Georges

\*Medicare

Grinn Hospitalization, Inc.  
5412th Street, S.W.  
Washington, D.C. 20024

Mutual of Omaha Insurance Company J

Kansas (continued)

Maryland (continued)

Rest of State:

\*Medicare  
Maryland Medical Service, Inc.  
700 E. Joppa Road  
Towson, Maryland 21204

Massachusetts

\*Medicare  
Massachusetts Blue Shield  
90 Mason Street  
Boston, Massachusetts 02110

Aetna Life and Casualty J

The Travelers Insurance Company J

Michigan

\*Massachusetts Blue Cross, Inc.  
133 Federal Street  
Boston, Massachusetts 02110  
Aetna Life and Casualty J

The Travelers Insurance Company J

Minnesota

Michigan Hospital Service  
441 East Jefferson Avenue  
Detroit, Michigan 48226  
The Travelers Insurance Company J

Minnesota

Michigan Hospital Service  
441 East Jefferson Avenue  
Detroit, Michigan 48226  
The Travelers Insurance Company J

Minnesota

\*Medicare  
The Travelers Insurance Company  
8120 Penn Avenue, South  
Bloomington, Minnesota 55431  
Aetna Life and Casualty J

Rest of State:

\*Medicare  
Blue Shield of Minnesota  
P.O. Box 7899  
Minneapolis, Minnesota 55404

Minnesota

Minnesota Hospital Service  
Association  
3535 Blue Cross Road  
St. Paul, Minnesota 55111  
Aetna Life and Casualty J

Maryland

Maryland

Maryland







South Carolina

Blue Cross of South Carolina  
Drawer A, Forest Acres Branch  
1-10 East Alpine Road  
Columbia, South Carolina 29206

South Dakota

Associated Hospitals Service, Inc.  
1612 Pierce Street  
Sioux City, Iowa 51102

Aetna Life and Casualty 3

Mutual of Omaha Insurance Company 3

Vermont

Medicare  
Blue Shield of South Carolina  
Drawer F, Forest Acres Branch  
Columbia, South Carolina 29206

Virginia

Medicare  
South Dakota Medical Service, Inc.  
711 North Lake Avenue  
Sioux Falls, South Dakota 57102

Tennessee

Medicare  
Blue Cross-Blue Shield of Tennessee  
310 Chestnut Street  
Nashville, Tennessee 37202

McGill Hospital Service and  
Surgical Association  
P.O. Box 98  
Memphis, Tennessee 38101

Aetna Life and Casualty 3

\* New Hampshire-Vermont  
Hospitalization Service  
Two Pillbury Street  
Concord, New Hampshire 03301

The Travelers Insurance Company 3

Washington

Medicare  
Blue Cross of Virginia  
205 Staples Mill Road  
Richmond, Virginia 23205

Hospital Service Association of  
Roanoke  
1212 3rd Street SW.  
P.O. Box 2770  
Roanoke, Virginia 24001

Group Hospitalization, Inc.  
550 12th Street, S.W.  
Washington, D.C. 20024

Aetna Life and Casualty 3

Mutual of Omaha Insurance Company 3

West Virginia

Blue Cross Washington-Alaska, Inc.  
601 Broadway  
P.O. Box 327  
Seattle, Washington 98111

Aetna Life and Casualty 3

Mutual of Omaha Insurance Company 3

Utah

Blue Cross of Utah  
2455 Parley's Way  
P.O. Box 270  
Salt Lake City, Utah 84110

Mutual of Omaha Insurance Company 3

Vermont

\* Medicare  
New Hampshire-Vermont Physician  
Service  
Two Pillbury Street  
Concord, New Hampshire 03301

Virginia

Medicare  
Counties of:  
Fairfax  
Arlington  
City of:  
Alexandria

\* Medicare  
Medical Service of D.C.  
550 12th Street, S.W.  
Washington, D.C. 20024

Rest of State:

\* Medicare  
The Travelers Insurance Co.  
P.O. Box 26463  
Richmond, Virginia 23230

Washington

Medicare  
Washington Physicians' Service  
Mail to your local Medical Service  
Bureau

Virginia

\* Medicare  
Blue Cross of Virginia  
205 Staples Mill Road  
Richmond, Virginia 23205

The Travelers Insurance Company 3

West Virginia

Medicare  
Blue Cross Hospital Service, Inc.  
P.O. Box 1353 Commerce Square  
Charleston, West Virginia 25301

Parkersburg Hospital Service, Inc.  
203 Union Trust Building  
Parkersburg, West Virginia 26101

West Virginia

West Virginia (continued)

American Samoa

Hawai'i Medical Service Association  
P.O. Box 860  
Honolulu, Hawai'i 96808

American Samoa

Hawai'i Medical Service Association  
P.O. Box 860  
Honolulu, Hawai'i 96808

Mutual of Omaha Insurance Company ♀

Wisconsin

Associated Hospital Service, Inc.  
4115 North Devonia Avenue  
P.O. Box 2055  
Milwaukee, Wisconsin 53201

Actua Life and Casualty ♀

National of Omaha Insurance Company ♀

County of:

Milwaukee

Medicare

Surgical Care

P.O. Box 2049  
Milwaukee, Wisconsin 53201

Rest of State:

Medicare  
Wisconsin Physicians Service  
Box 1787  
Madison, Wisconsin 53701

Wyoming

Medicare?

The Equitable Life Assurance Society  
P.O. Box 628  
Cheyenne, Wyoming 82001

Puerto Rico

Puerto Rico

B.I.L.C. Cross of Puerto Rico  
P.O. Box 1431  
San Juan, Puerto Rico 00905  
Cooperativa de Seguros de Vida de  
Puerto Rico  
P.O. Box 3428  
San Juan, Puerto Rico 00936

Virgin Islands

Virgin Islands

Cooperativa de Seguros de Vida de  
Estado 240  
Q.D.O. 3428  
San Juan, Puerto Rico 00936  
Medicare  
Seguros De Servicio De Salud De  
Puerto Rico  
G.P.O. Box 3628  
Hato Rey, Puerto Rico 00936

West Virginia (continued)

American Samoa

Hawai'i Medical Service Association  
P.O. Box 860  
Honolulu, Hawai'i 96808

Guam

Hawai'i Medical Service Association  
P.O. Box 860  
Honolulu, Hawai'i 96808

Guam

Medicare  
Aetna Life and Casualty  
P.O. Box 3947  
Honolulu, Hawai'i 96812

NOTE: The Blue Cross Association, 810 North Lake Drive, Chicago, Illinois 60611, is the prime contractor for all Blue Cross Plans participating in the Hospital Insurance Program.

The Aetna Life and Casualty processes claims from providers of service from 28 States; The Travelers Insurance Company from 14 States; Mutual of Omaha Insurance Company from 27 States and the District of Columbia; and the Kaiser Foundation Health Plan Inc., 4 States. The main office for each of these companies is listed below.

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